wisconsin Medicaid update and BadgerCare

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Wisconsin Medicaid and BadgerCare Information for Providers

To:

Home Health Agencies

Nurse Practitioners

Nurses in Independent Practice

HMOs and Other Managed Care Programs

Revised Prior Authorization Home Care Attachment and Plan of Care Requirements for Home Health and Private Duty Nursing Services

This *Wisconsin Medicaid and BadgerCare Update* contains revisions to Section VI — Signatures of the Prior Authorization/ Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A (Dated 09/05) and the PA/HCA form, HCF 11096 (Dated 09/05). When developing a recipient's plan of care (POC) for Wisconsin Medicaid home care services, home health agencies and nurses in independent practice are required to include the information as it is requested in Section VI — Signatures of the PA/HCA Completion Instructions.

This *Update* applies to both recipient POC completed using the PA/HCA and recipient POC completed using another format that contains all of the components requested in the PA/HCA Completion Instructions.

This *Update* also contains information about the POC certification period and the PA period, and details about when to include the PA number on a POC.

Some providers have indicated that they understand that the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A (Dated 09/05), apply only to plans of care (POC) prepared for requests for prior authorization (PA). To assure that providers fully understand the requirements for completing the POC, Wisconsin Medicaid has extended the effective date for the use of the components requested in the PA/HCA Completion Instructions for POC that are not submitted with PA requests.

Effective Date for the Plan of Care

Certification periods with a "From" date of May 1, 2006, or later as indicated in Element 4 of the PA/HCA must include all the components of the *revised* PA/HCA Completion Instructions on each POC completed.

Plan of Care Certification Period Versus Prior Authorization Period

Providers are reminded that the POC certification period and the PA period refer to two separate time periods.

The requirements for a recipient's POC as stated in the PA/HCA Completion Instructions apply to the POC certification period. Regardless of the PA period (which in some cases can be granted for up to one year), the POC must be completed at least every 62 days.

Revised Instructions for the Plan of Care

In response to provider questions, Wisconsin Medicaid has released revised PA/HCA Completion Instructions, HCF 11096A (Rev. 03/06)

and a revised PA/HCA form, HCF 11096 (Rev. 03/06). Providers may obtain the revised PA/HCA Completion Instructions and revised PA/HCA form from the Medicaid Web site or from Attachments 1 and 2 of this *Wisconsin Medicaid and BadgerCare Update*.

Each provider should respond to the PA/HCA Completion Instructions consistent with his or her provider type and the services being provided under the POC.

All POC for home care services reimbursed by Wisconsin Medicaid must include all of the components requested in the PA/HCA Completion Instructions. Although the requested information is required, providers may use either the PA/HCA or develop another form as long as it contains all of the components of the PA/HCA Completion Instructions.

Completing the Plan of Care

The PA/HCA Completion Instructions for Element 24 require the registered nurse (RN) *completing* the POC to sign the PA/HCA. To *complete* the POC, the RN is required to do all of the following:

- Develop the nursing POC.
- Review the information provided in the POC to assure that all required components are included.
- Review the information provided in the POC to assure that it is correct.

Under ch. N 6.03, Wis. Admin. Code, an RN is responsible for the POC. Under ch. N 6.04, Wis. Admin. Code, a licensed practical nurse may *assist* with the development and revision of the POC.

Someone other than the RN may key the required components into the document, but the RN signing the PA/HCA takes full responsibility for the contents of the POC.

Information Requested in Elements 24 and 25

Regardless of whether the physician's order is for the start of care with the initial certification period or for continuing care with a recertification period, the RN completing the POC is required to sign and date the PA/HCA. By signing and dating the PA/HCA, the RN attests to the following:

- The information contained in the POC is complete and accurate.
- He or she is familiar with all of the information in the POC.
- When providing services, he or she is responsible for ensuring that the POC is carried out as specified.

Regardless of whether the physician's order is for the start of care with the initial certification period or for continuing care with a recertification period, the RN completing the POC is required to sign and date the PA/HCA.

Elements 24 and 25 must be completed on or before the certification period "From" date indicated in Element 4 of the PA/HCA.

Information Requested in Element 26

If the nurse signing and dating Elements 24 and 25 receives *verbal* orders from the attending physician to start care for the *initial* certification period, the nurse should enter the date the verbal orders were received in Element 26. If the nurse did not receive verbal orders, Element 26 should be left blank.

Flexible Use of Hours for Private Duty Nursing

When the flexible use of hours is requested for private duty nursing, providers are required to specify the date that the flexibility period will begin. The PA/HCA Completion Instructions for Element 15 direct providers to include the begin date for the use of flexible hours under this element on the PA/HCA. The begin date must be a date covered under the current POC.

Case Sharing By Two or More Nurses in Independent Practice

When two or more nurses in independent practice (NIP) share a case, it is necessary to designate only one RN who receives the physician's orders to complete Elements 24 and 25. Often, the designated RN is also the case coordinator.

Each NIP sharing the case is required to obtain a copy of the PA/HCA for the effective certification period and *countersign* and *date* Elements 31 and 32 to document that he or she has reviewed the POC and will execute it as written. The countersigned document is a *copy* of the physician-signed document. The countersigned copy of the POC must be retained with the nurse's records.

Although PA may be granted for up to one year, the POC must be completed at least every 62 days.

For each certification period that the countersigning nurse provides services, he or she is required to *countersign* and *date* Elements 31 and 32 *before* providing services. A nurse may obtain a copy of the PA/HCA and countersign and date Elements 31 and 32 after the certification period "From" date indicated in Element 4; however, the nurse may *not* submit claims for services provided before the date he or she countersigned in Elements 31 and 32.

When a nurse that is not designated to receive the physician's orders requests PA, he or she is required to submit a *countersigned* and *dated* copy of the PA/HCA with the Prior Authorization Request Form (PA/RF), HCF 11018, that includes all of the elements as requested in the PA/HCA Completion Instructions.

The nurse designated to receive the physician's orders is not required to keep copies of any PA/HCA countersigned by the other nurses. Each nurse is required to retain only his or her own documentation.

Prior Authorization Number on Plans of Care

Although PA may be granted for up to one year, the POC must be completed at least every 62 days. Including the PA number on a POC that is *not* being submitted with a PA request is optional. However, Wisconsin Medicaid *recommends* that providers include the PA number on the POC even when it is optional. A PA number has record keeping advantages for the nurses on the case and will make the POC easier to reference in the future.

Information Regarding Medicaid HMOs

This *Update* contains Medicaid fee-for-service policy and applies to providers of services to recipients on fee-for-service Medicaid only. For Medicaid HMO or managed care policy, contact the appropriate managed care organization. Wisconsin Medicaid HMOs are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *Wisconsin Medicaid and BadgerCare Update* is the first source of program policy and billing information for providers.

Although the *Update* refers to Medicaid recipients, all information applies to BadgerCare recipients also.

Wisconsin Medicaid and BadgerCare are administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For questions, call Provider Services at (800) 947-9627 or (608) 221-9883 or visit our Web site at *dhfs.wisconsin.gov/medicaid/*.

PHC 1250

ATTACHMENT 1
Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions

(A copy of the Prior Authorization/Home Care Attachment [PA/HCA] Completion Instructions is located on the following pages.)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The Prior Authorization/Home Care Attachment (PA/HCA), HCF 11096, is a plan of care (POC) that may be completed for Wisconsin Medicaid recipients receiving home care services. The information on this form is mandatory. The use of this form is voluntary, and providers may develop their own form as long as it includes all of the components requested on this form. If necessary, attach additional pages if more space is needed. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Retain the original, signed PA/HCA. Attach a copy of the PA/HCA to the Prior Authorization Request Form (PA/RF), HCF 11018, and submit it to Wisconsin Medicaid along with any attached additional information. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616 or by mail to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services which are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Prior Authorization Number
Enter the unique seven-digit number from the PA/RF. Enter the same PA number in the spaces provided at the top of each subsequent page of the form. Providers are encouraged, but not required, to include the PA number on POC that are not submitted for PA, but are prepared for recertification periods.

Element 2a — Name and Telephone Number — Recipient
Enter the name and telephone number, including the area code, of the recipient. If the recipient's telephone number is not available, enter "N/A."

Element 2b — Recipient Medicaid Identification Number
Enter the recipient's Medicaid identification number (optional).

Element 3 — Start of Care Date
Enter the date that covered services began for the recipient in MM/DD/YY format (e.g., March 13, 2005, would be 03/13/05). The start of care date is the date of the recipient's first billable home care visit. This date remains the same on subsequent POC until the recipient is discharged.

Element 4 — Certification Period
Enter the beginning and ending dates of the recipient's certification period respectively in the "From" and "To" portions of this element in the MM/DD/YY format. The certification period identifies the period of time approved by the attending physician for the POC.

The "To" date can be *up to*, but not more than, 62 days later than the "From" date. (Medicare-certified agencies should use the timeframe of up to, but not more than, *60 days* later.) For certification periods that cover consecutive 31-day months, providers should be careful not to exceed 62 days.

Services provided on the "To" date are included in the certification period. On subsequent periods of recertification, the certification period should begin with the day directly following the date listed as the "To" date in the immediately preceding certification period.

Example:

Initial Certification Period	
"From" date	12/01/04
"To" date	01/31/05

Subsequent Recertification Period	
"From" date	02/01/05
"To" date	04/03/05

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

Element 5 — Principal Diagnosis
Enter the principal diagnosis information. Include the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code, diagnosis code description, and the date of onset in MM/DD/YY format. If the recipient's condition is chronic or long-term in nature, use the date of exacerbation.

Element 6 — Surgical Procedure and Other Pertinent Diagnoses
Enter the surgical procedure information, if any, that is relevant to the care rendered or the services requested. Include the appropriate ICD-9-CM diagnosis code, diagnosis code description, and the date of the surgical procedure in MM/DD/YY format. The month and year of the date of the surgical procedure must be included. Use "00" if the exact day of the month is unknown (e.g., March 2005, would be 03/00/05).

Enter all other diagnoses pertinent to the care rendered for the recipient. Include the appropriate narrative or ICD-9-CM diagnosis code, code description, and the date of onset in MM/DD/YY format. Include all conditions that coexisted at the time the POC was established or that subsequently developed. Exclude conditions that relate to an earlier episode not associated with this POC. Other pertinent diagnoses in this element may be changed to reflect changes in the recipient's condition.

If a relevant surgical procedure was not performed and there are no other pertinent diagnoses, enter "N/A" (do not leave the element blank).

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

Element 7 — Durable Medical Equipment
Identify the item(s) of durable medical equipment (DME) ordered by the attending physician and currently used by the recipient. Enter "N/A" if no known DME has been ordered.

Element 8a — Functional Limitations
Enter an "X" next to all items that describe the recipient's current limitations as assessed by the attending physician and the nurse or therapist. If "Other" is checked, provide further explanation in Element 8b.

Element 8b
If "Other" is checked in Element 8a, specify the other functional limitations.

Element 9a — Activities Permitted
Enter an "X" next to all activities that the attending physician permits and/or that are documented in the attending physician's orders. If "Other" is checked, provide further explanation in Element 9b.

Element 9b
If "Other" is checked in Element 9a, specify the other activities the recipient is permitted.

Element 10 — Medications
Enter the attending physician's orders for all of the recipient's medications, including the dosage, frequency, and route of administration for each. If any of the recipient's medications cause severe side effects or reactions that necessitate the presence of a nurse, therapist, home health aide, or personal care worker, indicate the details of these circumstances in this element.

Element 11 — Allergies
List any medications or other substances to which the recipient is allergic (e.g., adhesive tape, iodine, specific types of food). If the recipient has no known allergies, indicate "no known allergies."

Element 12 — Nutritional Requirements
Enter the attending physician's instructions for the recipient's diet. Include specific dietary requirements, restrictions, fluid needs, tube feedings, and total parenteral nutrition.

Element 13 — Mental Status
Enter an "X" next to the term(s) that most accurately describes the recipient's mental status. If "Other" is checked, provide further explanation.

Element 14 — Prognosis
Enter an "X" next to the one term that specifies the most appropriate prognosis of the recipient.

SECTION IV — ORDERS

Element 15 — Orders for Services and Treatments
Indicate the following as appropriate for each individual service:

- Number of recipient visits (e.g., home health skilled nursing, home health aide, or medication management), frequency of visits, and duration of visits ordered by the attending physician's orders (e.g., 1 visit, 3 times/week, for 9 weeks).
- Number of hours required for recipient visits (e.g., private duty nursing [PDN] or personal care), frequency of visits, and duration of visits ordered by the attending physician (e.g., 8 hours/day, 7 days/week, for 9 weeks).
- Duties and treatments to be performed.
- Methods for delivering care and treatments.
- Procedures to follow in the event of accidental extubation, as applicable.
- Ventilator settings and parameters, as applicable.

Services include, but are not limited to, the following:

- Home health skilled nursing.
- Home health aide.
- Private duty nursing.

Orders must include all disciplines providing services for the recipient and all treatments the recipient receives regardless of whether or not the services are billable to Wisconsin Medicaid. Orders indicated on this POC should be as detailed and specific as those ordered and written by the attending physician.

Pro re nata (PRN), or "as needed," home care visits or hours may be ordered on a recipient's POC only when indicating how these visits or hours will be used in a manner that is specific to the recipient's potential needs. Both the nature of the services provided and the number of PRN visits or hours to be permitted for each type of service *must* be specified. Open-ended, unqualified PRN visits or hours do not constitute an attending physician's orders because both the nature and frequency of the visits or hours *must* be specified.

When flexible use of PDN hours is requested, specify the date on which the flexibility period begins. The begin date specified for the use of flexible hours must be a date covered under this POC.

Nurses in independent practice (NIP) are required to include the name and license number of the registered nurse (RN) providing coordination services under this element. An NIP that is a licensed practical nurse is required to include the name and license number of the RN supervisor under this element.

Element 16 — Goals / Rehabilitation Potential / Discharge Plans
Enter the attending physician's description of the following:

- Achievable and measurable goals for the recipient.
- The recipient's ability to attain the set goals, including an estimate of the length of time required to attain the goals.
- Plans for the recipient's care after discharge.

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

Element 17 — Date Physician Last Saw Recipient
Enter the date the attending physician last saw the recipient in MM/DD/YY format. If this date cannot be determined during the home visit, enter "Unknown."

Element 18 — Dates of Last Inpatient Stay Within 12 Months
Enter the admission and discharge dates of the recipient's last inpatient stay within the previous 12 months, if known. Enter "N/A" if this element does not apply to the recipient.

Element 19 — Type of Facility for Last Inpatient Stay
Enter one of the following single-letter responses to identify the type of facility of the recipient's last inpatient stay, if applicable:

- A (Acute hospital).
- S (Skilled nursing facility).
- R (Rehabilitation hospital).
- I (Intermediate care facility).
- O (Other).
- U (Unknown).

This element must be completed if a surgical procedure was entered in Element 6. Enter "N/A" if this element does not apply to the recipient.

Element 20 — Current Information
For initial certifications, enter the clinical findings of the initial assessment visit for each discipline involved in the POC. Describe the clinical facts about the recipient that require home care services and include specific dates in MM/DD/YY format.

For recertifications, enter significant clinical findings about the recipient's symptoms, new orders, new treatments, and any changes in the recipient's condition during the past 60 days for each discipline involved in the POC. Document both progress and nonprogress for each discipline. Include specific dates in MM/DD/YY format.

Include any pertinent information about any of the recipient's inpatient stays and the purpose of contact with the physician, if applicable.

Element 21 — Home or Social Environment
Enter information that will justify the need for home care services and enhance the Medicaid consultant's understanding of the recipient's home situation (e.g., recipient lives with mentally disabled son who is unable to provide care or assistance to recipient). Include the availability of caretakers (e.g., parent's work schedule). The description may document problems that are, or will be, an impediment to the effectiveness of the recipient's treatment or rate of recovery.

Element 22 — Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home
Enter the reasons that the recipient usually leaves home. Indicate both medical and nonmedical reasons, including frequency of occurrence of the trips (e.g., doctor appointment twice a month, barbershop once a month, school every weekday for three hours).

Element 23 — Back-up for Staffing and Medical Emergency Procedures
This element is required for all providers requesting PDN services. It is optional for all other home care providers.

Enter the back-up plan for staffing and medical emergency procedures. The following information must be included in this element:

- A plan for medical emergency, including:
  - ✓ A description of back-up personnel needed.
  - ✓ Provision for reliable, 24 hours a day, 7 days a week emergency service for repair and delivery of equipment.
  - ✓ Specification of an emergency power source.
- A plan to move the recipient to safety in the event of fire, flood, tornado warning or other severe weather, or any other condition that threatens the recipient's immediate environment.

SECTION VI — SIGNATURES

Those signing the POC are to acknowledge their responsibilities and consequences for non-compliance. Provider-created formats must contain the following statement that is included on the PA/HCA:

> *"Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws."*

Elements 24 and 25 — Signature and Date Signed — Authorized Nurse Completing Form
The RN completing this PA/HCA is required to sign and date this form. The signature certifies that the nurse has received authorization from the attending physician to begin providing services to the recipient. These elements must be completed on or before the certification period "From" date indicated in Element 4.

Provider-created formats must contain the following statement accompanying the authorized nurse's signature:

> *"As the nurse completing this plan of care, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this plan of care is carried out as specified."*

Element 26 — Date of Verbal Orders for Initial Certification Period
Enter the date the nurse signing in Element 24 receives verbal orders from the attending physician to start care for the initial certification period. If the nurse did not receive verbal orders, leave this element blank.

Element 27 — Date Received Physician-Signed Form
Enter the date the PA/HCA signed by the attending physician was received by the nurse or in the agency.

Element 28 — Name and Address — Attending Physician
Enter the attending physician's name and complete address. The street, city, state, and zip code must be included. The attending physician establishes the POC, certifies, and recertifies the medical necessity of the visits and/or services provided.

Elements 29 and 30 — Signature and Date Signed — Attending Physician
The attending physician is required to sign and date the PA/HCA within 20 working days following the initial start of care. A recertification of the POC requires the attending physician to sign and date the new PA/HCA prior to the continued provision of services to the recipient.

Provider-created formats must contain the following statement accompanying the attending physician's signature:

"The recipient is under my care, and I have authorized the services on this plan of care."

Verbal authorization may be obtained from the attending physician for the initial certification period PA request. The recipient may then begin receiving home care services; however, the attending physician is required to sign the PA/HCA within 20 working days of the start of care date.

The attending physician may not give verbal authorization for certification period renewal PA requests. The attending physician is required to sign the PA/HCA prior to the continued provision of services to the recipient; home care services may not be provided until the attending physician's signature is obtained on the form.

The form may be signed by another physician who is authorized by the attending physician to care for the recipient in his or her absence.

The nurse or agency staff may not predate the PA/HCA for the attending physician or write the date in the field after it has been returned. If the attending physician has left Element 30 blank, the nurse or agency staff should enter the date the signed PA/HCA was received in Element 27.

Elements 31 and 32 — Countersignature and Date Signed — Nurse in Independent Practice
When two or more NIP share a case, it is necessary to designate only one RN who receives the physician's orders to complete Element 24. Often, the designated RN is also the case coordinator. Each NIP sharing the case is required to obtain a copy of the PA/HCA for the effective certification period and *countersign* and *date* Elements 31 and 32 to document that he or she has reviewed the POC and will execute it as written.

Provider-created formats must contain the following statement accompanying the authorized nurse's countersignature:

"As the nurse countersigning this plan of care, I confirm the following: All information on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this plan of care is carried out as specified."

ATTACHMENT 2
Prior Authorization/Home Care Attachment (PA/HCA)

(A copy of the Prior Authorization/Home Care Attachment [PA/HCA] is located on the following pages.)

DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11096 (Rev. 03/06)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME CARE ATTACHMENT (PA/HCA)

Instructions: Print or type clearly. Refer to the Prior Authorization/Home Care Attachment (PA/HCA) Completion Instructions, HCF 11096A, for information on completing this form.

SECTION I — RECIPIENT INFORMATION

1. Prior Authorization Number	2a. Name and Telephone Number — Recipient	2b. Recipient Medicaid Identification Number

3. Start of Care Date	4. Certification Period From To

SECTION II — PERTINENT DIAGNOSES AND PROBLEMS TO BE TREATED

5. Principal Diagnosis (ICD-9-CM Code, Description, Date of Diagnosis)	6. Surgical Procedure and Other Pertinent Diagnoses (ICD-9-CM Code, Description, Date of Procedure or Diagnoses)

SECTION III — BRIEF MEDICAL AND SOCIAL INFORMATION

7. Durable Medical Equipment

8a. Functional Limitations

1 ❑ Amputation	5 ❑ Paralysis	9 ❑ Legally Blind
2 ❑ Bowel / Bladder (Incontinence)	6 ❑ Endurance	10 ❑ Dyspnea with Minimal Exertion
3 ❑ Contracture	7 ❑ Ambulation	11 ❑ Other (Specify in Element 8b)
4 ❑ Hearing	8 ❑ Speech	

8b. If “Other” checked in Element 8a, specify other functional limitations.

9a. Activities Permitted

1 ❑ Complete Bedrest	6 ❑ Partial Weight Bearing	10 ❑ Wheelchair
2 ❑ Bedrest BRP	7 ❑ Independent at Home	11 ❑ Walker
3 ❑ Up As Tolerated	8 ❑ Crutches	12 ❑ No Restrictions
4 ❑ Transfer Bed / Chair	9 ❑ Cane	13 ❑ Other (Specify in Element 9b)
5 ❑ Exercises Prescribed		

9b. If “Other” checked in Element 9a, specify other activities permitted.

10. Medications (Dose / Frequency / Route)

11. Allergies

Continued

Prior Authorization Number

12. Nutritional Requirements

13. Mental Status
1 ❑ Oriented 3 ❑ Forgetful 5 ❑ Disoriented 7 ❑ Agitated
2 ❑ Comatose 4 ❑ Depressed 6 ❑ Lethargic 8 ❑ Other _____

14. Prognosis
1 ❑ Poor 2 ❑ Guarded 3 ❑ Fair 4 ❑ Good 5 ❑ Excellent

SECTION IV — ORDERS

15. Orders for Services and Treatments (Number / Frequency / Duration)

Continued

Prior Authorization Number

16. Goals / Rehabilitation Potential / Discharge Plans

SECTION V — SUPPLEMENTARY MEDICAL INFORMATION

17. Date Physician Last Saw Recipient	18. Dates of Last Inpatient Stay Within 12 Months (If Known)		19. Type of Facility for Last Inpatient Stay (If Applicable)
	Admission	Discharge	

20. Current Information (Summary from Each Discipline / Treatments / Clinical Facts)

21. Home or Social Environment

22. Medical and / or Nonmedical Reasons Recipient Regularly Leaves Home (Include Frequency)

Continued

Prior Authorization Number

23. Back-up for Staffing and Medical Emergency Procedures (Required for All Providers Requesting Private Duty Nursing Services / Optional for Other Home Care Services)

SECTION VI — SIGNATURES

Nurse Certification

As the nurse completing this PA/HCA, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

24. **SIGNATURE** — Authorized Nurse Completing Form	25. Date Signed — Authorized Nurse Completing Form

26. Date of Verbal Orders for Initial Certification Period	27. Date Received Physician-Signed Form

Physician Certification

The recipient is under my care, and I have authorized the services on this PA/HCA.

28. Name and Address — Attending Physician (Street, City, State, Zip Code)

29. **SIGNATURE** — Attending Physician	30. Date Signed — Attending Physician

Case Sharing Nurse in Independent Practice Certification

As the nurse countersigning this PA/HCA, I confirm the following: All information entered on this form is complete and accurate and I am familiar with all of the information entered on this form. When I am providing services, I am responsible for ensuring that this PA/HCA is carried out as specified.

31. **COUNTERSIGNATURE** — Nurse in Independent Practice (Only if Sharing Case)	32. Date Countersigned — Nurse in Independent Practice

Anyone who misrepresents, falsifies, or conceals essential information required for payment of state and/or federal funds may be subject to fine, imprisonment, or civil penalty under applicable state and/or federal laws.