Ohio Department of Medicaid

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

Individual's Name	Qualifying Treating Physician's Name
Individual's Medicaid Billing Number	Qualifying Treating Physician's Billing Number

About the ODM 07137 Form: Pursuant to 5160-12 of the Administrative Code, this form must be used to certify the medical necessity for home health services (Section I or II) and/or private duty nursing services (Section III) as ordered for the above-named individual by a qualifying treating physician. Only the qualifying treating physician may certify medical necessity. The form is also used to document a face-to-face encounter occurred with the above-named individual, as required and completed by the qualifying treating physician within ninety days prior to the start of home health care date, or within thirty days following the start of care date (OAC 5160-12-01). 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. **NOTE:** An individual's plan of care may be used to document medical necessity for home health services in lieu of this form, provided all of the data elements specified below in Section I are adequately contained in a prior authorized/approved plan of care.

About Home Health Services: Home health aide, home health (intermittent) nursing, and home health skilled therapies are covered by the Ohio Department of Medicaid (ODM) when certified as medically necessary and only if provided on a part-time or intermittent basis, which means: (1) No more than a combined total of eight hours per day of home health nursing, home health aide, and skilled therapies except as specified in 5160-12 of the Administrative Code for individuals under age twenty-one; (2) No more than a combined total of fourteen hours per week of home health nursing and home health aide services except as specified in 5160-12 of the Administrative Code or as prior authorized by ODM or its designee; and (3) Visits are not more than four hours in length. Pursuant to 5160-12-01 of the Administrative Code, home health services, additional home health service hours, and/or a combination of services may be certified as medically necessary for: (I) individuals with no related inpatient hospital stay, including individuals under age twenty-one and those under twenty-one in need of increased home health services under Healthchek; and (II) individuals discharged from a covered inpatient hospital stay, including individuals under age twenty-one, and those individuals under age twenty-one in need of increased home health services under Healthchek.

About Private Duty Nursing (PDN) Services: PDN services are covered by ODM when certified as medically necessary and only when continuous nursing service(s) that require the skills of either a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of a registered nurse are performed. A covered PDN visit must meet the conditions imposed in 5160-12-02 of the Administrative Code, the definition for PDN in 5160-12-04 of the Administrative Code, and be more than four hours in length but less than or equal to twelve hours in length per nurse, on the same date or during a twenty-four hour time period, unless exceptions noted in 5160-12-02(A) (1) – (A) (3) of the Administrative Code apply.

SECTION I of III

Certificate of Medical Necessity of Home Health Services for Individuals with Unrelated/Uncovered Inpatient Hospital Stay

Check all boxes that apply:

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

☐ By my signature below, I certify that I, or a collaborating advance practice nurse, or a physician assistant under my supervision conducted and documented a face-to-face encounter with the above named individual within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification of medical necessity.

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

Individual's Name	Qualifying Treating Physician's Name
Individual's Medicaid Billing Number	Qualifying Treating Physician's Billing Number

SECTION II of III

Certificate of Medical Necessity of Home Health Services for Individuals Discharged from a Covered Inpatient Hospital Stay

Check all boxes that apply:

☐ The above-named individual 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 individual. I certify that the individual needs home health 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 a collaborating advanced practice nurse, or a physician assistant under my supervision, conducted and a documented a face-to-face encounter with the above-named individual within ninety days prior to the home health services start of care date, or within thirty days following the start of care date, preceding this certification of medical necessity.

☐ By my signature below, I certify that the above-named individual has a level of care comparable to an institutional level of care as evidenced by the fact that the individual is enrolled on a waiver, or though not enrolled on a waiver, still meets at least one of the following criteria (*Check all boxes that apply*):

- ☐ 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, andcognition, 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 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.
- ☐ Is age 16 and older with at least one other diagnosed condition other than mental illness, the condition manifested before the individual'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-language 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
  - 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 the Face-to-Face Encounter	Face-to-Face Encounter Date
Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date

Individual's Name	Qualifying Treating Physician's Name
Individual's Medicaid Billing Number	Qualifying Treating Physician's Billing Number

Section III of III

Certificate of Medical Necessity of Post-Hospital Service for Private Duty Nursing (PDN) Services

Private duty nursing is continuous nursing provided by an RN or LPN in an individual's home, in visits and duration for more than four hours in length but less than or equal to twelve hours in length per nurse, on the same date or during a twenty-four hour time period, up to fifty-six hours per week.

Certification of medical necessity is required for post-hospital PDN up to sixty consecutive days from the date of discharge from an inpatient covered hospital stay of three or more consecutive overnights.

Check if applicable:

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

Discharge Date: _____

☐ By my signature below, I certify that the above-named individual 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 seven days a week and/or physical therapy, occupational therapy, or speech-language pathology to be delivered at least five 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.

Certifying Physician's Signature and Credentials	Certifying Physician's Signature Date