471-000-67 Instructions for Completing Form MS-81, "Certification and Plan of Care for Private-Duty Nursing"

Use: Providers of private-duty nursing services (RN/LPN's and licensed home health agencies) use Form MS-81 to document the client's Plan of Care and the physician's orders for skilled nursing services provided to Medicaid clients.

Completion: RNs, LPNs, and licensed home health agencies complete Form MS-81 as follows:

1. Client Case number: Enter the client's nine-digit Medicaid number, and the two-digit ID number. These numbers are on the client's Medicaid card or Nebraska Health Connection ID document. When billing for services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 2-006.06).

   It is essential to check the client's Medicaid eligibility at the beginning of each month PRIOR to providing services. For information regarding client eligibility, managed care and copay requirements call:

   Outside Lincoln 800-642-6092
   Lincoln . . . . . (402) 471-9580

2. Start of Care Date: Enter the date that service was originally started.

3. Certification Period: Enter the to and from dates which cover the period that care is to be provided. The period cannot exceed 62 days, i.e., From 1-1-04 to 3-1-04.

4. Client's Name, Address and Telephone Number: Enter the client's name, address and telephone number.

5. Provider's Name, Address and Telephone Number: Enter the provider's name, address and telephone number.

6. Date of Birth: Enter the client's date of birth.

7. Sex: Check the client's sex.

8. Medications: Enter all current medications that the client is taking, including dose/frequency, and route. Indicate those medications that are new or have been changed during this certification period.

9. ICD-CM Code, Primary Diagnosis and Date: Check one of the ICD boxes. Enter the ICD-CM diagnosis code for the primary diagnosis. This code can be obtained from the physician. State the primary diagnosis and the date the diagnosis was made. For dates of services on or before September 30, 2015 only ICD-9 codes will be accepted on this form. For dates of service on or after October 1, 2015 only ICD-10 codes will be accepted.

10. Other Pertinent Diagnosis: Enter all other current diagnoses that have a relationship to the care that is being provided. Enter the date that each diagnosis was made.

11. DME and Supplies: Enter all durable medical equipment and supplies that the client is currently using that has a relationship to the care that is being provided.

12. Safety Measures: Enter all safety measures currently used in the care of the client, i.e., oxygen at bedside, transfer with Hoyer lift, etc.

13. Diet: Enter the current diet of the client.

14. Allergies: Enter any allergies known to the client.

15A. Functional Limitations: Check all limitations that apply to the client.

15B. Activities Permitted: Check all activities that apply to the client.

16. Mental Status: Check all that apply to the client.

17. Orders for Discipline and Treatments (specify type/frequency/ duration): Enter the physician's order for skilled nursing services, indicating the type (RN or LPN) (visit or # hours), frequency of the service, and the duration of the service which cannot exceed 62 days.

18. Client's Current Medical Status: Enter brief statement regarding the client's current medical status that has a relationship to the skilled nursing services being requested.

19. Abilities/Functional Limitations/Impairments: Enter the client's abilities/functional limitations/impairments that have a relationship to the skilled nursing services being requested.

20. Goals/Rehabilitation Potential/Discharge Plans: Enter the client's goals/rehabilitation potential/discharge plans which have a relationship to the skilled nursing services being requested.

21. Living Arrangements, Caregivers Availability and Environmental Risks: Enter the client's living arrangements, any caregivers availability, and any environmental risks which have a relationship to the skilled nursing services being requested.

22. Physician's Name and Address: Enter the prescribing physician's name and address.

23. Attending Physicians Signature and Date: The attending/prescribing physician must sign and date this order for skilled nursing services.

24. Provider Signature: The provider must sign and date.

25. Provider Number: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12).

26. Prior-Authorization Number: The State or its designee will enter the prior-authorization number, the skilled nursing services approved, and initial the authorization. This prior-authorization number will be entered by the provider on the billing form.

Distribution: Form MS-81 in its entirety is sent to authorizing agent.

Retention: The provider retains his/her copy of Form MS-81 for six years for audit purposes.

To view printable form click here: Certification and Plan of Care for Private-Duty Nursing

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Certification and Plan of Care for Private-Duty Nursing

1. Client Case No:	ID No:
2. Start of Care Date:	3. Certification Period From: to:
4. Client's Name, Address and Telephone Number:	5. Provider's Name, Address and Telephone Number:
6. Date of Birth: 7. Sex ☐ M ☐ F	8. Medications: Dose/Frequency/Route: (N) New (C) Changed
9. ICD Indicator: ☐ ICD-9 ☐ ICD-10	
Primary Diagnosis Code:	
Date:	
10. Other Pertinent Diagnosis Code:	
Date:	
Other Pertinent Diagnosis Code:	
Date:	
11. DME and Supplies	12. Safety Measures
13. Diet	14. Allergies:

15a. Functional Limitations:

- ☐ Amputation
- ☐ Bowel/Bladder (Incontinence)
- ☐ Contracture
- ☐ Hearing
- ☐ Paralysis
- ☐ Endurance
- ☐ Ambulation
- ☐ Speech
- ☐ Legally Blind
- ☐ Dyspnea with Minimal Exertion
- ☐ Other (Specify) _____

15b. Activities Permitted:

- ☐ Complete Bed Rest
- ☐ Best Rest BRP
- ☐ Up as Tolerated
- ☐ Transfer Bed/ Chair
- ☐ Partial Weight
- ☐ Independent at Home
- ☐ Crutches
- ☐ Cane
- ☐ Exercise as Prescribed
- ☐ Wheelchair
- ☐ Walker
- ☐ No Restrictions
- ☐ Other (Specify) _____

16. Mental Status: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic ☐ Other

17. Orders for Discipline and Treatments (Specify Type/Frequency/Duration):

18. Clients Current Medical Status:

19. Abilities/Functional Limitations/Impairments:

20. Goals/Rehabilitation Potential/Discharge Plans:

21. Living Arrangements, Caregivers Availability and Environmental Risks:

22. Physicians Name and Address:	24. Providers Signature:	Date:
	25. Providers Number:	
	26. Prior Authorization #:	
23. Attending Physician's Signature: Date:	Services Approved:	
The Patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		

MS-81 Rev. 5/15 (27077)
(Previous version 4/98 should NOT be used)