Division of TennCare

# KATIE BECKETT PART A PHYSICIAN CERTIFICATION of MEDICAL NECESSITY

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| **Child's Name:** Type Name. | **SSN:** Enter SSN here. |
| **Age:** Enter Age here. | **Date of Birth:** Enter DOB here. |

***This certification must be completed by a Physician (MD or DO), Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist—PLEASE INITIAL <u>EACH</u> ITEM BELOW.***

| Initials | I certify each of the following: |
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| | I am the treating physician (or other qualified treating medical provider as specified above) for the above-named child. This means that I have personally provided medical evaluation and treatment and have an ongoing relationship as this child's health care provider. |
| | I have sufficient knowledge of the above-named child's physical, behavioral and functional needs to certify the level of care this child requires. |
| | The above-named child has medical needs that are likely to last at least 12 months or result in death and which result in severe functional limitations. |
| | Because of these needs, the above-named child would require the level of care provided in the type of medical institution(s) indicated below. |
| | If not for the availability of home-based services, care in the type of medical institution(s) indicated below would be medically necessary and appropriate. |
| | If home-based services are available, the needs of the above-named child can be safely met at home. |
| | I understand that in order for the PAE to be approved, a medical history and physical or other medical records must be provided to document the child's medical, behavioral, and functional needs and support medical necessity for the level of care indicated below. |

**Initial all that apply:**

| Initials | I certify that the above-named child requires the following level(s) of care in a medical institution: |
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| | The above-named child has a severe, lifelong chronic medical condition with high mortality and morbidity rates resulting in severe functional limitations and complex medical needs and requires continuous (round the clock) assessment and one or more of the following direct, continuous skilled medical interventions including the use of medical equipment to sustain life, and without such assistance is at imminent risk of institutionalization within an in-patient medical hospital.<br>• Ventilator care or non-invasive positive pressure ventilation when required for at least 8 hours per day as a life-sustaining measure for chronic respiratory failure;<br>• Tracheostomy care requiring suctioning multiple times each 8-hour period;<br>• Oxygen administration for chronic hypoxia requiring at least 8 hours of oxygen use daily, round the clock monitoring of O2 saturation levels, and titration of O2 levels administered;<br>• Parenteral Nutrition (TPN); and/or Dialysis: hemodialysis or peritoneal, in home or at clinic. |
| | The above-named child has severe or profound deficits in intellectual and/or adaptive behavior functions, which must include significant communication deficits or Autism and a severe or profound communication disorder AND also has frequent and intensive dangerous behaviors (i.e., self-injurious or physically aggressive) and without continuous (round the clock) supervision and monitoring and direct, daily community-based therapeutic support and intervention is at **imminent risk for institutionalization in an inpatient psychiatric hospital or other placement outside the home** |

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| | (e.g., residential treatment, State custody, or incarceration). |
| | The above-named child **meets at least ONE of the standards below**, requires an extraordinary (continuous or nearly continuous) level of hands on assistance from others throughout their day to complete everyday activities and supervision/intervention that is significantly beyond that which is routinely provided to other children of the same age, and without the availability of such assistance, would require the level of care provided in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).<br>• **Requires daily skilled nursing interventions and/or intensive therapy services AND** has **at least TWO (2) substantial functional limitations** in activities of daily living.<br>• Meets ALL of the following:<br>1) Has a **severe or profound intellectual disability including significant communication deficits OR has autism and a severe or profound communication disorder**; **AND**<br>2) Severe co-occurring behavioral health support needs, **including self-injurious behaviors or physically aggressive behaviors** toward others; **AND**<br>3) **At least TWO substantial functional limitations** in activities of daily living.<br>• Has an **I/DD AND at least FOUR (4) substantial functional limitations** in activities of daily living. |

| **Please list all diagnoses relevant to this certification** |
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**I understand that this information will be used to determine the above-named child's eligibility and/or reimbursement for TennCare, including home- and community-based services. I understand that any intentional act on my part to provide false information that would potentially result in a person obtaining benefits or coverage to which s/he is not entitled is considered an act of fraud under the state's TennCare program and Title XIX of the Social Security Act. I further understand that, under the Tennessee Medicaid False Claims Act, any person who presents or causes to be presented to the State a claim for payment under the TennCare program knowing such claim is false or fraudulent is subject to federal and state civil and criminal penalties.**

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| **Signature of Certifier** | **Credentials** |
| **Printed Name of Certifier** | **Date Signed** |