



Plan of Care

Care Planning, Coordination of Services, and Quality of Care



42 CFR 484.60

Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. **The individualized plan of care must specify the care and services necessary to meet the patient-specific needs** as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training.

Services must be furnished in accordance with accepted standards of practice.

Standard: Plan of Care



484.60(a)

484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

484.60(a)(2) The individualized plan of care must include the following:

- 484.60(a)(2)(i)
All pertinent diagnoses
- 484.60(a)(2)(ii)
The patient[']s mental, psychosocial, and cognitive status
- 484.60(a)(2)(iii)
The types of services, supplies, and equipment required
- 484.60(a)(2)(iv)
The frequency and duration of visits to be made
- 484.60(a)(2)(v)
Prognosis
- 484.60(a)(2)(vi)
Rehabilitation potential
- 484.60(a)(2)(vii)
Functional limitations
- 484.60(a)(2)(viii)
Activities permitted
- 484.60(a)(2)(ix)
Nutritional requirements



484.60(a)(2) The individualized plan of care must include the following: (continued)

- 484.60(a)(2)(x)
All medications and treatments
- 484.60(a)(2)(xi)
Safety measures to protect against injury
- 484.60(a)(2)(xii)
A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors
- 484.60(a)(2)(xiii)
Patient and caregiver education and training to facilitate timely discharge
- 484.60(a)(2)(xiv)
Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
- 484.60(a)(2)(xv)
Information related to any advanced directives
- 484.60(a)(2)(xvi)
Functional Any additional items the HHA or physician may choose to include
- 484.60(a)(3)
All patient care orders, including verbal orders, must be recorded in the plan of care



Medicare Benefit Policy Manual – Chapter 7 – Home Health Services: Content of Plan of Care:

The HHA must be acting upon a physician or allowed practitioner plan of care that meets the requirements of this section for HHA services to be covered. For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician or allowed practitioner after any needed consultation with the qualified therapist
- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments
- The plan must include the expected duration of therapy services
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged	
11. ICD	Principal Diagnosis		Date		
12. ICD	Surgical Procedure		Date		
13. ICD	Other Pertinent Diagnoses		Date		
14. DME and Supplies			15. Safety Measures		
16. Nutritional Req.			17. Allergies		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status			5 <input type="checkbox"/> Disoriented		7 <input type="checkbox"/> Agitated
	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed			
20. Prognosis			1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair
			4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent	
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date of HHA Received Signed POT

24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

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

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

I certify/ recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred 12/1/2021 within timeframe requirements and it is related to the primary reason the patient requires home health services.

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

Some items required on the POC aren't listed in some EMR's

Examples:

- Risk of hospitalization
- Advance directives
- Attestation to the F2F date by the certifying physician

- Ensure your EMR has ALL required elements for the POC or ensure they are added on each POC.



Should you include a patient admission summary on the POC:

YES!

- Our signed POC is supplemental documentation to support the F2F.
- A patient summary that lists the reason the patient is requiring home health justifies the skilled need for home health. Sometimes the Physician's F2F visit doesn't always have enough detail to support home health services.

Medicare Benefit Policy Manual – Chapter 7 – Home Health Services

Supporting Documentation Requirements (Rev. 10438, Issues: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

- While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician or allowed practitioner, acute/post-acute care facility, and/or HHA (see below).



Survey Tag Regarding the Plan of Care:

- 484.50(c)(5) – Receive all services in plan of care – G436
- 484.60(a)(1) – Standard: plan of care – G572
- 484.60(a)(2) – Plan of care must include the following – G574
- 484.60(a)(3) – All orders recorded in plan of care – G576
- 484.60(c) – Standard: Review and revision of the plan of care – G586
- 484.60(c)(1) – Reviewed, revised by physician every 60 days
- 484.60(c)(1) – Promptly alert relevant physician of changes
- 484.60(c)(2) – Revised plan of care – G592
- 484.60(c)(3) – Plan of care revisions must be communicated – G594
- 484.75(b)(2) – Development and evaluation of plan of care – G708
- 484.75(b)(3) – Provide services in the plan of care – G710
- 484.102(b)(1) – Plans of HHA's patient in the plan of care (Emergency Prep) – E0017
- 484.105(c)(5) – Assure implementation of plan of care – G968





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Thank You

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