Medicare
Program Integrity Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1981

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
6	3 3.1 3.2 3.3 3.4 3.5 3.6 3.7		
		3.8	
Exhibits		29 30 31	

NEW/REVISED MATERIAL--EFFECTIVE DATE: May 2, 2002
IMPLEMENTATION DATE: May 2, 2002

Chapter 6, Section 3.1, Form CMS-485 - Home Health Certification and Plan of Care Data, clarifies the use of Form CMS-485 (the plan of care form) is not a CMS requirement. However, Home Health Agencies (HHAs) must have all required plan of care data elements contained in a readily identifiable location within the medical record.

Chapter 6, Section 3.2, Addendum to Form CMS-485 Plan of Care, provides HHAs the discretion to use a preprinted addendum to the plan of care when needed or any other format signed and dated by the physician.

Chapter 6, Section 3.3, Medical Review of Home Health Claims, instructs contractors to notify providers that they have 30 days to submit medical records for MR purposes but if the documentation is not received within 45 days, to make a MR determination based on available documentation. This section instructs contractors that they cannot reject the claim or return the claim to the provider when medical records are not submitted by the provider.

Chapter 6, Section 3.4.1, General, instructs contractors that once they establish that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record. It instructs contractors not to conduct MR on the request for anticipated payment (RAP).

Chapter 6, Section 3.4.2, Types of Review, defines pre-claim and post-claim review. It instructs contractors to target MR primarily on a pre-claim targeted basis.

Chapter 6, Section 3.4.3, MR Process, should be conducted after validating provider/service specific billing errors.

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Chapter 6, Section 3.4.4, Claim Selection, instructs contractors to initially target MR on areas of PPS vulnerability, with a shift to data analysis as it becomes available.

Chapter 6, Section 3.4.5, Record Request, specifies examples of medical record documentation that may be necessary to conduct MR.

Chapter 6, Section 3.4.6, Record Review, suggests limits to MR.

Chapter 6, Section 3.4.7, Outcome of Review, instructs contractors what to do with MR findings.

Chapter 6, Section 3.4.8, Data Analysis, explains the use of data analysis as a tool in identifying target areas for MR.

Chapter 6, Section 3.5, Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care, clarifies part-time or intermittent care requirements.

Chapter 6, Section 3.6,Treatment Codes for Home Health Services, references a new exhibit.

Chapter 6, Section 3.7, Effectuating Favorable Final appellate Decision that a Beneficiary is "Confined to Home," instructs contractors what to do when a favorable final appellate decision that a beneficiary is "confined to home" is received.

Chapter 6, Section 3.8, Reporting, informs contractors that the Program Integrity Management Reports (PIMR) will, when operational, will extract data electronically for existing systems to meet reporting requirements for prepay MR. However, post-payment reviews still need to be reported manually.

Exhibit 29, Description of Items on Form CMS-485, provides a description for each item contained on this form..

Exhibit 30, Treatment Codes, a new exhibit which describes treatment codes used for home health services.

Exhibit 31, Form CMS-485, Home Health Certification and Plan of Care, is a new exhibit.

These instructions should be implemented within your current operating budget.

NOTE*:* **Red italicized font identifies new material.**

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Chapter 6 - Intermediary MR Guidelines for Specific Services

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3 - Medical Review of Home Health Services - (Rev. 23, 03-18-02)

To qualify for Medicare coverage of home health services, a beneficiary must be under the care of a physician who establishes the plan of care (POC). The POC must contain specific items as listed in 42 CFR section 484.18(a). The POC must be signed and dated by a physician. The physician must be qualified to sign the certification and POC in accordance with 42 CFR section 424.22. The physician must sign and date the POC before the claim for services is submitted. The home health agency (HHA) may provide services prior to obtaining the physician's written plan of care based on documented verbal orders. If care continues beyond the certification period, the HHA must obtain a re-certification from the physician.

3.1 - Form CMS-485 - Home Health Certification and Plan of Care Data - (Rev. 23, 03-18-02)

Standardized data collection facilitates accurate coverage decisions, helps to ensure correct payment for covered services and promotes compliance with Federal laws and regulations. Form CMS-485 (the Home Health Certification and Plan of Care- see Exhibit 31) meet regulatory and national survey requirements for the physician's plan of care, certification and re-certification. Form CMS-485 provides a convenient way to submit a signed and dated POC. However, HHAs may submit any document that is signed and dated by the physician that contains all of the required data elements in a readily identifiable location within the medical record and in accordance with the current rules governing the home health POC. The signed POC is maintained in the beneficiary's medical record at the HHA with a copy of the signed POC available upon request when needed for medical review (MR). Providers may submit the POC electronically if acceptable to the Regional Home Health Intermediary (RHHI). HHAs

are required to obtain a signed POC as soon as practical after the start of care and prior to submitting the claim. A description of the Form CMS-485 data elements can be found in Exhibit 29.

3.2 - Addendum to Form CMS-485 Plan of Care - (Rev. 23, 03-18-02)

When additional space is needed to complete Form CMS-485 fields, HHAs use an addendum *signed and dated by the physician.*

3.3 - Medical Review of Home Health Claims - (Rev. 23, 03-18-02)

In reviewing the POC and/or other medical information, the Regional Home Health Intermediary (RHHI) makes a MR determination on the entire certification period or beyond if services are continued. If the RHHI determines that services are non-covered from the Start of Care (SOC) or at some point during the billing period, the RHHI must ensure the appropriate controls are in place so that subsequent claims are suspended for appropriate action.

RHHIs may deny visits/services based upon information provided on the POC. However, additional information or a copy of the medical record must be requested when objective clinical evidence needed to support a decision is not clearly present. (See the Medicare Intermediary Manual,§3116.1.) RHHIs do not deny claims because a field on Form CMS-485 has not been completed. If the missing information is needed to make a coverage determination, it must be requested. When requesting additional documentation for medical review purposes, notify providers that the requested documentation is to be submitted to the RHHI within 30 days of the request. However, if the documentation needed to make a MR determination is not received within 45 days from the date of the documentation request, make a MR determination based on the available medical documentation. Do not reject the claim or return the claim to the provider. If the claim is denied, deny payment or collect the overpayment. Follow the procedures below when conducting MR.

- *Missing or Incomplete Physician's Orders*

    - *Visits for a discipline are billed but there is no physician order, or the physician order is present but is not specific, or there is no frequency.*

    - *RHHIs request a copy of the physician's order for the services. RHHIs accept a documented verbal order or signed written order. (See below for Acceptable Verbal Orders.) They do not accept orders signed after the service(s) is rendered unless there is evidence of a pre-existing verbal order. If the agency is furnishing services without a physician's order, deny the services. RHHIs*

advise the HHA that the findings may be reported for possible referral to the State survey office if patterns of missing orders are noted.

- *Physician's order for discipline and frequency is present but there is no duration of visits.*

  - *RHHIs make a medical necessity determination on the duration billed.*

- *Agency provides fewer visits than the physician orders.*

  - *RHHIs do not deny claims because the agency provides fewer visits than ordered. The agency should be reporting decreases in visits to the physician. When an agency is consistently decreasing visits without reporting it to the physician, you may notify the State survey office when appropriate.*

- *Documentation of physician's verbal orders.*

  - *When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician before the HHA bills for the care in the same way as the plan of care. There are no required forms or format for documentation or confirmation of verbal orders. In the absence of documentation of verbal orders, RHHIs accept a notarized statement from the physician that he/she gave verbal orders before the services were rendered.*

3.4 - Medical Review of Home Health Prospective Payment System (HH PPS) Claims (Date of Service on or After 10/1/2000) – (Rev. 23, 03-18-02)

3.4.1 - General - (Rev. 23, 03-18-02)

RHHIs are to conduct MR of Medicare HH PPS claims focusing efforts at areas that affect payment. Once it is established that the episode met Medicare coverage

requirements and was billed appropriately, it may not be necessary to continue review of the record. The goal of MR is to determine whether services provided are reasonable and necessary, delivered and coded correctly, and appropriately documented. Some of the terminology used to describe MR will change with the HH PPS. For example, in a cost-based system, prepayment MR means MR conducted prior to making a payment. Postpayment MR means MR conducted after making a payment. Under the HH PPS, most MR will be conducted after an initial payment is made, e.g., request for anticipated payment (RAP), but before payment of the claim. MR will not be conducted on the RAPs. RHHIs must meet workload requirements while staying within MR budget allocations

3.4.2 - Types of Review - (Rev. 23, 03-18-02)

Review conducted prior to payment of the claim is called "pre-claim review". Medical review may also be conducted following payment of the claim. This type of review is called "post-claim review". Targeted MR should be conducted primarily on a pre-claim targeted basis. Targeted reviews may also be conducted on a post-claim basis if data analysis supports review. CMS recognizes the value of random review in identifying normal practice patterns, aberrancies, and potential vulnerabilities under the PPS. Random MR of HH PPS claims should be conducted primarily on a post-claim basis until implementation of the Comprehensive Error Rate Testing (CERT) program or until further instructions are issued by CMS.

3.4.3 - MR Process - (Rev. 23, 03-18-02)

MR should be conducted after validating provider/service specific billing errors. Consider the principles of Progressive Corrective Action (PCA) when conducting MR. (See Change Request 1285 "Medical Review--Progressive Corrective Action," dated August 7, 2000.)

3.4.4 - Claim Selection - (Rev. 23, 03-18-02)

Targeted review should focus on specific program vulnerabilities inherent in the PPS until data analysis identifies provider/service specific problems. Providers with high error rates, newly participating providers, referrals from State Survey Agencies, other CMS reviews, etc. may also be targeted for medical review. It may be appropriate to flag subsequent claims when full or partial denials of previous beneficiary specific episodes have been made.

3.4.5 - Record Request - (Rev. 23, 03-18-02)

RHHIs must request documentation necessary to make a MR determination. The requested documentation may include, but is not limited to, physician orders and progress notes; patient care plans; the comprehensive assessment; the OASIS; nursing and rehabilitation therapy notes; treatment and flow charts and vital sign records, weight charts and medication records; discharge summary notice; and other home health medical record documentation. We expect that review of the bill (UB-92) alone would not provide sufficient information to make a MR determination. When requesting additional documentation for MR purposes, notify providers that the requested documentation is to be submitted to the contractor within 30 days of the request.

3.4.6 - Record Review - (Rev. 23, 03-18-02)

For all selected claims, review medical documentation and determine whether the services provided were covered. Conduct medical review to the extent necessary to ensure all qualifying criteria are met, and the medical documentation supports payment at the HIPPS code billed. More extensive review of the claim may not be an efficient use of MR resources except when there is concern over the appropriateness of an outlier payment. If the documentation needed to make a MR determination is not received within 45 days from the date of the documentation request, make a MR determination based on the available medical documentation. Do not reject the claim or return the claim to the provider (RTP).

In order to be covered, a service must meet all three of the following criteria:

- *Beneficiaries must continue to meet the home health eligibility requirements as described in MIM §3117 (e.g., whether the beneficiary is under a plan of care established and approved by a physician, under the care of a physician, confined to the home, and in need of qualifying skilled services).*

- *The services must not be statutorily excluded. Determine whether the services are excluded from coverage under any provision in §1862(a) of The Social Security Act (the Act) other than §1862(a)(1)(A) of the Act.*
- *Services are Reasonable and Necessary. Determine whether the services are reasonable and necessary under §1862(a)(1) of the Act.*

NOTE: *Once it is established that the episode met Medicare coverage requirements and was billed appropriately, it may not be necessary to continue review of the record.*

3.4.7 - Outcome of Review - (Rev. 23, 03-18-02)

If MR determines that the coverage criteria were not met at the beginning of the episode and continue not to be met during the duration of the episode, deny the entire episode. If MR determines a beneficiary or services provided do not meet the coverage criteria at

some point during the episode, disallow or line item deny the services provided once the coverage criteria are not met if this action would result in a change of payment.

When data analysis indicates a need to look closely at the HHRG billed, review the OASIS information and other medical documentation in the beneficiary's medical record using the ROVER software or other efficient means. If documentation in the medical record creates significant doubt about the validity of the home health agency response, the reviewer should treat the response as incorrect and mark the response category indicating the condition or level of impairment indicated by the medical record documentation. If this action results in a new HHRG, record the new HHRG in the designated panel field on the claim. If as a result of MR, the payment made is less than the payment billed, the difference is considered a partial denial.

If during a review it is determined that a HHA does not comply with the conditions of participation, do not deny payment solely for this reason. Refer to the applicable State Survey Agency.

If it is determined that services are provided without physician orders, disallow or line item deny the services. Consider referring under-service issues to the State Survey Agency.

If it is determined that any of the services billed were not furnished, disallow or line item deny the services that were not furnished. If this action results in a new HHRG, record the new HHRG in the designated panel field on the claim. If fraudulent billing practices are suspected, refer to your Fraud Unit. See Chapter 4 of the PIM regarding actions to be taken when there is suspected fraudulent billing.

3.4.8 -- Data Analysis - (Rev. 23, 03-18-02)

Use data analysis as a tool in identifying target areas for MR according to the guidelines in Chapter 2 of the PIM. RHHIs should conduct data analysis of PPS claims, consider data from other sources (PROs, carriers, Medicaid) and referrals from internal or external sources (e.g., provider audit, fraud and abuse units, beneficiary or other complaints) to ensure efficient targeting of MR efforts where there is the greatest risk to the Medicare trust funds.

3.4.9 - Medicare Integrity Program- Provider Education and Training (MIP-PET) - (Rev. 23, 03-18-02)

The HHA PPS is a new payment methodology. Education is key to ensure proper billing. As billing problems are identified, RHHIs should not only educate the individual providers of problems, but also the home health community about the common billing problems identified through MR. This education should be as interactive as possible. RHHIs should be proactive in using the results of MR to educate providers and prevent

future errors. The costs associated with these activities are to be budgeted and charged to the MIP-PET CAFM2 code 24001.

3.5 - Medical Review of Skilled Nursing and Home Health Aide Hours for Determining Part-Time or Intermittent Care - (Rev. 23, 03-18-02)

The RHHI requests medical documentation when it suspects that care is not part-time or intermittent care and makes decisions based on the documentation. They:

- *Request entrance and exit times of SN and aide visits;*
- *Review hours spent in the home in accordance with MIM §3119.7;*
- *For part-time care, approve medically necessary visits beginning before the 35th hour a week and before the 8th hour a day; and*
- *For intermittent care, approve medically necessary visits beginning before the 35th hour of a week or approve medically necessary daily full-time care, up to and including 8 hours per day for finite and predictable periods. The 8 hours a day limit does not apply if the RHHI is approving less than daily care.*

Do not make a decision that covered care could be accomplished in fewer hours if visits are determined to be covered and services are part-time or intermittent.

3.6 - Treatment Codes for Home Health Services - (Rev. 23, 03-18-02)

*The agency may use the narrative explanation for the treatment codes, which represent the services to be furnished. The narrative is entered in Item 21 of Form CMS-485. Additional narrative is required under Item 21 of Form CMS-485 to describe specific services, e.g., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. (See asterisked items/services in Exhibit30.) Non-asterisked items/services do not require additional narrative unless the physician has ordered specific treatment and/or use of prescription medications and/or non-routine supplies. Listing of a code for a particular service is not intended to imply coverage. The codes are to ease identification of services ordered by the physician whether or not these services are payable individually by Medicare. Physician's orders reflect a narrative description of treatment a*nd services to be furnished. *A description of treatment codes can be found in Exhibit 30.*

3.7 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home" - (Rev. 23, 03-18-02)

***A. General Information**--RHHIs are instructed to do the following when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.*

NOTE: *For the purposes of this manual section a favorable decision is a decision that is favorable to the beneficiary. A final appellate decision is a decision at any level of the appeals process where the RO has finally determined that no further appeals will be taken, or where no appeal has been taken and all time for taking an appeal has lapsed.*

- *Promptly pay the claim that was the subject of the favorable final appellate decision.*
- *Promptly pay or review based on the review criteria below:*
- *All claims that have been denied that are properly pending in any stage of the appeals process.*
- *All claims that have been denied where the time to appeal has not lapsed.*
- *All future claims submitted for this beneficiary.*
- *For favorable final appellate decisions issued during a one-year grace period starting on July 1, 2000, and ending June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.*
- *Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.*
- *Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.*
- *Maintain records containing information on the beneficiaries receiving favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HCIN number, service date of the claim that received the favorable final appellate decision and the date of this decision. This information should be made available to CMS upon request.*

B. ***Review Criteria--****Afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision unless there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if (a) there has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home and (b) if the services provided meet all other criteria for home health care. If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review.*

EXAMPLE 1

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical review determinations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to the home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed and the ability to leave the home had improved then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary's ability to leave the home.

3.8 - Reporting - (Rev. 23, 03-18-02)

The Program Integrity Management Reports (PIMR) system, when operational, will extract data electronically from existing systems (e.g., your standard system, CAFM, CROWD, etc.) to meet all medical review savings, workload, and cost reporting requirements. However, post-payment reviews will still need to be reported manually.

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21 - Regional Home Health Intermediaries/Jurisdictions

22 - Office of Inspector General, Office of Investigations Field Offices

23 - PIM Acronyms

24 - CMS Forms 700 and 701

25 - Form Letter for DOJ Requests

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27 - National Medicare Fraud Alert

28 - Restricted Medicare Fraud Alert

29 - Description of Items on Form CMS-485

30 - Treatment Codes for Home Health Services

31 - Form CMS-485

Exhibit 29 - Description of Items Contained on Form CMS-485 (Rev. 23, 03-18-02)

The following items are contained on the Form CMS-485:

No	*Data Element*	*Description:*
1	*Patient's HICN*	*The HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.*
2	*SOC Date*	*The HHA enters the month, day, year on which covered home health services began, i.e., MMDDYYYY (03012000). The SOC date is the first Medicare billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health may be suspended and later resumed under the same SOC date in accordance with the HHA's internal*

		procedures.
3	*Certification Period*	*a. For Dates of Service before the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period. EXAMPLE: Initial certification "From" date 03012000; Initial certification "To" date 05012000; Re-certification "From" date 05012000; Re-certification "To" date 07012000.* *b. For Dates of Service on or after the effective date of HH PPS (October 1, 2000): The HHA enters the month, day, year, e.g., MMDDYYYY, that identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed, 60 days. EXAMPLE: Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001.* ***NOTE:*** *Services delivered on 11292000 are covered in the initial certification episode.*
4	*Medical Record No*	*This is the patient's medical record number that is assigned by the HHA and is an* ***optional*** *item. If not applicable, the agency enters "N/A."*
5	*Provider No.*	*This is the 6-digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).*
6	*Patient's Name and Address*	*The HHA enters the patient's last name, first name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code.*
7	*Provider's Name, Address and Telephone No*	*The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code and telephone number.*
8	*Date of Birth*	*The patient's date of birth (month, day, year) in numbers, i.e., MMDDYYYY (04031920) is entered.*

9	*Sex*	*The patient's sex is checked in the appropriate box.*
10	*Medications: Dose, Frequency, Route*	*The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed.* *Drugs, which cannot be listed on the plan of care due to lack of space, are listed on an addendum.*

- *The letter "N" is used after the medication(s) that are "new" orders.*
- *The letter "C" is used after the medication(s) that are "change" orders either in dose, frequency or route of administration.*
- *"New" medications are those that the patient has not taken recently, i.e., within the last 30 days.*
- *"Change" are medications which include dosage, frequency or route of administration changes within the last 60 days.*

11	*Principal Diagnosis, ICD-9-CM Code and Date of Onset, Exacerbation*	*The principal diagnosis is the diagnosis most related to the current POC. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered.* *In certain cases, ICD-9-CM calls for more than one code to report a condition; this requirement, termed "multiple coding of diagnoses," often involves both a disease and one of its manifestations. The ICD-9-CM manual clearly shows the instances where manifestation coding is required. These codes must appear in their proper sequence as the first secondary diagnosis. ICD-9-CM sequencing requirements for manifestation codes are indicated in two ways in the ICD-9-CM manual. First, manifestation codes are indicated in the index to diseases where two codes are listed after a specific condition, with the second code in brackets. Second, manifestation codes are indicated in the tabular list where codes appear in italicized letters. Codes italicized in the tabular list can never appear in the primary diagnosis field, and must be preceded by the code for the underlying condition. Every italicized code in the tabular list is accompanied by instructions to report the code for the etiology first.*

Using the ICD-9-CM coding guidelines, the HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. Prior to the effective date of HH PPS, V codes are acceptable as primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. After the implementation of HH PPS, the primary diagnosis must match on the POC, the OASIS, and the UB-92. In addition, V codes are NOT acceptable as primary or first secondary diagnoses, but could be recorded in item 21 entitled Orders for Discipline and Treatments. The ICD-9-CM coding guidelines should be followed in assigning an appropriate V code.

EXAMPLES: *(Prior to the effective date of HH PPS): 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture.*

2) Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

EXAMPLES: *(After the effective date of HH PPS): 1) Patient is surgically treated for a subtrochanteric fracture (code 820.22). Her past medical history includes controlled HTN but the patient currently has chronic urinary tract infection (on medication) that the nurse will monitor for treatment effectiveness. Admission to home care is for rehabilitation following the hip fracture and surgery. The physician orders the agency to provide PT for gait training and exercise 3 times per week for four weeks. The HHA uses 781.2, abnormality of gait as the primary diagnosis and 599.0, urinary tract infection, site not specified; additional code to identify organism, if known; and V57.1, physical therapy.*

Discussion: The treatment is directed at rehabilitation following the hip fracture and surgery. OASIS instructs home care agencies to code the relevant medical diagnosis when a V code for rehabilitation therapy (followed by a symptom code for abnormality of gait) would normally be assigned. Although the hip fracture is the medical diagnosis relevant to the surgery, and would be equally acceptable under OASIS logic, we chose abnormality of gait because it more accurately describes her current condition and need for therapy (i.e., technically, she no longer has a hip fracture, which was resolved by the hospital surgical treatment) and because the physician specified gait training. If the plan of care called for the nurse or physical therapist to also carry out wound care, then the V-

code for attention to surgical dressings and sutures (V59.3) would be added.

2) Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Even though V55.3 is more specific to the nature of the proposed service, the HHA must use code 153.2 as the primary diagnosis and may use V55.3 as a second secondary diagnosis or in field 21.

Reporting the Principle Diagnosis on the POC must comply with the OASIS reporting restrictions, agencies should report the medical diagnosis relevant to the surgery for M0230/M0240 when V-codes for post-operative wound care would otherwise be used. Agencies should reserve injury and poisoning ICD-9 codes (categories 800-995) for injuries from accidents or violence. Surgical complications codes are available from ICD-9, however, they should not be used inappropriately to fill the gap left by the OASIS restrictions. The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established POC.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

12	*Surgical Procedure, Date, ICD-9-CM Code*	*The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 11 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.52, Partial Hip Replacement, 060998).*

If a surgical procedure was not performed or is not relevant to the POC, N/A is inserted. The addendum is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

13	*Other Pertinent Diagnoses: Dates of Onset/Exacerbation ICD-9-CM Code*	*Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the POC was established, or which developed subsequently, or that affect the treatment of care. Exclude diagnoses that relate to an earlier episode which have no bearing on this POC. It is expected that these diagnoses include not only conditions active with the patient, but also any comorbidity affecting the patient's responsiveness to treatment and rehabilitative prognosis, even if the condition is not the focus of any home health treatment itself. Agencies should avoid listing diagnosis that are of mere historical interest and without impact of patient progress or outcome.*

These diagnoses can be changed to reflect changes in the patient's condition. However, they must match the diagnoses listed on the OASIS and the UB-92, and conform with the ICD-9-CM coding guidelines.

In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. However, there may be exceptions to this rule, dictated by ICD-9-CM coding sequencing requirements. For example, if a principle diagnosis exists which dictates the utilization of a specific secondary diagnosis, then the agency should list this secondary diagnosis first in the list of "other pertinent diagnoses". If there are more than four pertinent secondary diagnoses, use an addendum to list them. Enter N/A if there are no pertinent diagnoses.

The date reflects either the date of onset if it is a new diagnosis or the date of the most recent exacerbation of a previous diagnosis. Note that the date of onset or exacerbation must be as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

14	*DME and Supplies*	*All non-routine supplies must be specifically ordered by the physician or the physician's order for services must require use of the specific supplies. The HHA enters in this item non-routine supplies that it is billing to Medicare that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley, catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require use of non-routine supplies, which would vary by patient. Therefore, the non-routine supplies would be listed.*

If the HHA lists a commonly used commercially packaged kit, it is not required to list the individual components. However, if there is a question of cost or content, the RHHI can request a breakdown of kit components.

RHHIs should reference the HIM 11, §206.4 for a definition of non-routine supplies.

The HHA also lists DME ordered by the physician that will be billed to Medicare. The HHA enters N/A if no supplies or DME are billed.

15	*Safety Measures*	*The physician's instructions for safety measures are listed.*
16	*Nutritional Requirements*	*The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item or under medications if more space is needed.*
17	*Allergies*	*Medications to which the patient is allergic are listed. In*

		addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.
18A	*Functional Limitations*	*All items that describe the patient's current limitations as assessed by the physician and the agency are indicated.*
18B	*Activities Permitted*	*The activity(ies) that the physician allows and/or for which physician orders are present are indicated.*

If "Other" is checked under Item 18A or 18B, a narrative explanation is required.

19	*Mental Status*	*The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, the patient's condition is specified here.*
20	*Prognosis*	*A check is placed in the box, which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent.*

***NOTE**: The number or letter adjacent to the blocks in Items 18 though 20 correspond to the codes for EMC transmission only.*

21	*Orders for Discipline and Treatments (Specify Amount, Frequency, Duration)*	*The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: SN, PT, ST, OT, MSS, or AIDE.*

Orders must include all disciplines and treatments, even if they are not billable to Medicare. In general, the narrative explanation for applicable treatment codes is acceptable as the order when that narrative is sufficiently descriptive of the services to be furnished. (See PIM Chapter 6 §3.6). However, additional explanation is required in this item to describe specific services, i.e., A1, A4, A5, A6, A7, A22, A23, A28, A29, A32, B15, C9, D11, E4, E6, and F15. Additional explanation is also required where the physician has ordered specific treatment, medications or supplies. When aide services are needed to furnish personal care, an order for "personal care" is sufficient. See example of orders below.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

A range of visits may be reflected in the frequency (e.g., 2 to 4 visits per week). When a range is used, consider the upper limit of the range the specific frequency. An agency may use ranges if acceptable to the physician without regard to diagnosis or other limits.

Example of Physician's Orders: Certification period is from 03012000 - 05012000:

OT - Eval., Activities of Daily Living (ADL) training, fine motor coordination 3x/wk x 6wks
ST - Eval., speech articulation disorder treatment 3x/wk x 4wks
SN - Skilled observation and assessment of C/P and neuro status instruct meds and diet/hydration 3x/wk x 2wks
MSS - Assessment of emotional and social factors 1x/mo x 2mos
AIDE - Assist with personal care, catheter care 3x/wk x 9wks

Specific services rendered by physical, speech and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

***EXAMPLE:** PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2wks.*

PRN visits may be ordered on a plan of treatment only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the plan of care. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature nor the frequency of the service is specified.

***EXAMPLE:** Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.*

22	*Goals/Rehabilitation Potential/Discharge Plans*	*This reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.*

Examples of realistic goals:

- *Independence in transfers and ambulating with walker;*
- *Healing of leg ulcer(s);*
- *Maintain patency of Foley catheter. Decrease risk of urinary infection;*
- *Achieve optimal level of cardiovascular status. Medication and diet compliance; and*
- *Ability to demonstrate correct insulin preparation/administration.*

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to nature of the

patient's condition and ability to respond. The words "Fair," or "Poor" alone, are not acceptable. Instead, descriptors must be added:

EXAMPLE: *Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.*

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

23	*Nurse's Signature and Date of Verbal Start of Care*	*This verifies for surveyors, CMS' representatives, and the RHHI that a registered nurse, qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker), or any health professional responsible for furnishing or supervising the patient's care, spoke to the attending physician and received verbal authorization to visit the patient. This date **may** precede the SOC date in Item 2 and may precede the "From" date in Item 3.*

When services are furnished based on a physician's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations, as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. The HHA enters N/A if the physician has signed and dated Form CMS-485 on or before the SOC or re-certification date, or has submitted a written order to start, modify, or continue care on a document other than Form CMS-485.

24	*Physician's Name and Address*	*The agency prints the physician's name and address. The attending physician is the physician who established the plan of treatment and who certifies and re-certifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the addendum only. The physician must be qualified to sign the certification and plan of care in accordance with 42 CFR 424 Subpart B. Physicians who have significant ownership interest in, or a significant financial or contractual relationship with an HHA may not establish or review a plan of treatment or certify or re-certify the need for home health services.*

25	*Date HHA Received Signed Plan of Care*	*The date the agency received the signed POC from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27 DATE is completed.*
26	*Physician Certification*	*This statement serves to verify that the physician has reviewed the POC and certifies to the need for the services.*
27	*Attending Physician's Signature and Date*	*The attending physician signs and dates the plan of care/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature. HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, State surveyor, or other authorized personnel or in the event of a system breakdown.*

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POC under Item 25.

28	*Penalty Statement*	*This statement specifies the penalties imposed for misrepresentation, falsification or concealment of essential information on the Form CMS-485.*

Exhibit 30 - Treatment Codes (Rev. 23, 03-18-02)

A -- Skilled Nursing

These represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

*A1 **	*Skilled Observation and Assessment (Inc. V.S., Response to Med., etc)*	*Includes all skilled observation and assessment of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)*
A2	*Foley Insertion*	*Insertion and/or removal of the Foley catheter by nurse.*
A3	*Bladder Instillation*	*Instilling medications into the bladder.*
*A4**	*Open Wound Care/Dressing*	*Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) on an addendum, when necessary. See A28 for observation uncomplicated surgical incision.*
*A5**	*Decubitus Care (Partial tissue loss with signs of infection or full thickness tissue loss, etc.)*	*Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance on an addendum when necessary. Use this code only if the decubitus being treated presents the following characteristics: 1 -- Partial tissue loss with signs of infection such as foul odor or purulent drainage; 2 -- Full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.*

		For care of decubitus not meeting this definition, see A29.
*A6**	*Venipuncture*	*The HHA specifies the test and frequency to be performed under physician's orders.*
*A7**	*Restorative Nursing*	*Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe non-skilled services (e.g., routine range of motion exercises).*
A8	*Post Cataract Care*	*Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See MIM §3117.4.A.)*
A9	*Bowel/Bladder Training*	*Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified. (See MIM §3114.4.E.1.)*
A10	*Chest Physio (Including postural drainage)*	*Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.*
A11	*Adm. of Vitamin B-12*	*Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines. (See MIM §3117.4.)*
A12	*Adm. Insulin*	*Preparation of insulin syringes for administration by the patient or other person, or the administration by the nurse.*
A13	*Adm. Other IM/Subq*	*Administration of any injection other than vitamin B-12 or insulin ordered by the physician.*
A14	*Adm. IVs/ Clysis*	*Administration of intravenous fluids or clysis or intravenous medications.*

A15	*Teach Ostomy or Ileo conduit care*	*Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.*
A16	*Teach Nasogastric Feeding*	*Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.*
A17	*Reinsertion Nasogastric*	*Includes changing the tube by the nurse.*
A18	*Teach Gastrostomy Feeding*	*Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.*
A19	*Teach Parenteral Nutrition*	*Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.*
A20	*Teach Care of Trach*	*Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.*
A21	*Adm. Care of Trach*	*Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.*
A22	*Teach Inhalation Rx.*	*Teaching patient or other person to administer therapy and care for equipment.*
*A23**	*Adm. Inhalation Rx*	*Administration of inhalation treatment and care of equipment by the nurse.*
A24	*Teach Adm. of Injection*	*Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)*

A25	*Teach Diabetic Care*	*Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).*
A26	*Disimpaction/F.U. Enema*	*Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.*
*A27**	*Other (Spec. Under Orders)*	*Includes any skilled nursing or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (Form CMS-485).*
*A28**	*Wound Care/Dressing – Closed Incision/Suture Line*	*Skilled observation and care of surgical incision/suture line including application of dry sterile dressing. (See A4.)*
*A29**	*Decubitus Care*	*Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, other than that described in A5. The HHA describes size (depth and width) and appearance on the addendum.*
A30	*Teach Care of Any Indwelling Catheter*	*Teaching patient or other person to care for indwelling catheter.*
A31	*Management and Evaluation of Patient Care Plan*	*The complexity of necessary unskilled services require skilled management of a registered nurse to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.*
*A32**	*Teaching and Training (other) (spec. under Orders)*	*Specify under physician orders.*

** Code which requires a more extensive descriptive narrative for physician's orders.*

B -- Physical Therapy (PT)

These codes represent all services to be performed by the physical therapist. If services are provided by a nurse, they are included under A7. The following is a further explanation of each service:

B1	*Evaluation*	*Visit(s) made to determine the patient's condition, physical therapy plans and rehabilitation potential; to evaluate the home environment to eliminate structural barriers and to improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).*
B2	*Therapeutic Exercise*	*Exercises designed to restore function. Specific exercise techniques (e.g., Proprioceptive Neuromuscular Facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques, which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion.*
B3	*Transfer Training*	*To evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and care-givers in appropriate transfer techniques.*
B4	*Establish or Upgrade Home Program*	*To improve the patient's functional level by instruction to the patient and responsible individuals in exercise which may be used as an adjunct to PT programs.*
B5	*Gait Training*	*Includes gait evaluation and ambulation training of a patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic*

		appliances, crutches, walker, cane, etc.).
B6	*Pulmonary Physical Therapy*	*Includes breathing exercises, postural drainage, etc., for patients with acute or severe pulmonary dysfunction.*
B7	*Ultra Sound*	*Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.*
B8	*Electro Therapy*	*Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, Transcutaneous Electrical Nerve Stimulation (TENS), Functional Electrical Stimulation (FES), biofeedback, High Voltage Galvanic Stimulation (HVGS), etc.).*
B9	*Prosthetic Training*	*Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.*
B10	*Fabrication Temporary Devices*	*Includes fabrication of temporary prostheses, braces, splints, and slings.*
B11	*Muscle Re-education*	*Includes therapy designed to restore function due to illness, disease, or surgery affecting neuromuscular function.*
B12	*Management and Evaluation of a Patient Care Plan*	*The complexity of necessary unskilled services require skilled management by a qualified physical therapist to ensure that these services achieve their purpose, and to promote the beneficiary's recovery and medical safety.*
B13	*Reserved*	

B14	*Reserved*	
B15	*Other (Spec. Under Orders)*	*Includes all PT services not identified above. Specific therapy services are identified under physician's orders (Form CMS-485, Item 21).*

** Code which requires a more extensive descriptive narrative for physician's orders.*

C -- Speech Therapy (ST)

These codes represent the services to be performed by the speech therapist. The following is a further explanation of each service.

C1	*Evaluation*	*Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.*
C2	*Voice Disorders Treatments*	*Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.*
C3	*Speech Articulation Disorders Treatments*	*Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements – usually referred to as apraxia/dyspraxia.*
C4	*Dysphagia Treatments*	*Includes procedures designed to facilitate and restore a functional swallow.*
C5	*Language Disorders Treatments*	*Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written*

		language expression, and/or arithmetical processes.
C6	*Aural Rehabilitation*	*Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.*
C7	*Reserved*	
C8	*Non-oral Communications*	*Includes any procedures designed to establish a non-oral or augmentive communication system.*
*C9**	*Other (Spec. Under Orders)*	*Speech therapy services not included above. Specify service to be rendered under physician's orders (Form CMS-485, Item 21).*

** Code which requires a more extensive descriptive narrative for physician's orders.*

D -- Occupational Therapy

These codes represent the services to be rendered by the occupational therapist. The following is a further explanation of each service:

D1	*Evaluation*	*Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of care, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.*
D2	*Independent Living/Daily Living Skills (ADL Training)*	*Refers to the skills and performance of physical cognitive and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.*
D3	*Muscle Re-education*	*Includes therapy designed to restore function lost due to disease or surgical intervention.*
D4	*Reserved*	

D5	*Perceptual Motor Training*	*Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities, which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.*
D6	*Fine Motor Coordination*	*Refers to the skills and the performance in fine motor and dexterity activities.*
D7	*Neurodevelop-mental Treatment*	*Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses, which are coordinated at subcortical and cortical levels.*
D8	*Sensory Treatment*	*Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and factory awareness necessary to increase function.*
D9	*Orthotics Splinting*	*Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.*
D10	*Adaptive Equipment (Fabrication and Training)*	*Refers to the provision of special devices that increase independent functions.*
*D11**	*Other*	*Occupational therapy services not quantified above.*

** Code which requires a more extensive descriptive narrative for physician's orders.*

E -- Medical Social Services (MSS)

These codes represent the services to be rendered by the medical social service worker. The following is a further explanation of each service:

E1	*Assessment of Social and Emotional Factors*	*Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.*
E2	*Counseling for Long-Range Planning and Decision making*	*Assessment of patient's needs for long term care including: Evaluation of home and family situation; enabling patient/family to develop an in-home care system; exploring alternatives to in-home care; or arrangement for placement.*
E3	*Community Resource Planning*	*The promotion of community centered services(s) including education, advocacy, referral and linkage.*
*E4**	*Short Term Therapy*	*Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.*
E5	*Reserved*	
*E6**	*Other (Specify Under Orders)*	*Includes other medical social services related to the patient's illness and need for care. Problem resolution associated with high risk indicators endangering patient's mental and physical health including: Abuse/neglect, inadequate food/medical supplies; and high suicide potential. The service to be performed must be written under doctor's orders (Form CMS-485, Item 21).*

** Code which requires a more extensive descriptive narrative for physician's orders.*

F -- Home Health Aide

These codes represent the services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. The following is a further explanation of each service:

F1	*Tub/Shower Bath*	*Assistance with tub or shower bathing.*
F2	*Partial/Complete Bed Bath*	*Bathing or assisting the patient with bed bath.*
F3	*Reserved*	
F4	*Personal Care*	*Includes shaving of patient or shampooing the hair.*
F5	*Reserved*	
F6	*Catheter Care*	*Care of catheter site and/or irrigations under nursing supervision.*
F7	*Reserved*	
F8	*Assist with Ambulation*	*Assisting the patient with ambulation as determined necessary by the nurse care plan.*
F9	*Reserved*	
F10	*Exercises*	*Assisting the patient with exercises in accordance with the plan of care.*
F11	*Prepare Meal*	*May be furnished by the aide during a visit for personal care.*
F12	*Grocery Shop*	*May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.*
F13	*Wash Clothes*	*This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate*

		environment.
F14	*Housekeeping*	*Household services incidental to care and which do not substantially increase the time spent by the home health aide.*
*F15**	*Other (Specify Under Orders)*	*Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Form CMS-485, Item 21.*

** Code which requires a more extensive descriptive narrative for physician's orders.*

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Exhibit 31

Form Approved
OMB No. 0938-0357

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 ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ 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 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 the 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.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861, and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to : Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.