Use of this template is voluntary / optional

Home Health Services Plan of Care / Certification Template

Purpose

This template has been designed to assist the physician in documenting the Home Health Services Plan of Care / Certification in establishing the Medicare beneficiary's eligibility and need for home health services. 42 CFR 484.60, Condition of participation: Care planning, coordination of services, and quality of care, requires that *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.*

42 CFR 424.22 requires that as a physician certification in order to pay for home health services under Medicare Part A or Medicare Part B. 42 CFR 424.22(a)(2) requires the certification of need for home health services must be obtained at the time the plan of treatment (care) is established or as soon thereafter as possible and must be signed by the physician who establishes the plan. The certification must also document when a F2F encounter was performed.

As described in 42 CFR 424.22, a F2F encounter must be performed and related to the primary reason the patient requires home health services. The F2F encounter be performed no more than 90 days prior to the home health start of care date or within 30 days after the start of the home health care. The F2F encounter must be performed by the certifying physician, a physician (with privileges) who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health, or allowed Non-Physician Practitioner (NPP)[1] who does not have a financial relationship with the Home Health Agency (HHA) (unless the financial relationship meets one of the exceptions set forth in §411.355 through §411.357 of the Act).

Patient Eligibility for Coverage of Home Health Services under Medicare

For a Medicare beneficiary to be eligible to receive Medicare home health services, the physician must certify that:

1. The patient needs or needed: a. intermittent skilled nursing care;
   b. physical therapy;
   c. speech-language pathology services; or

[1] A Medicare allowed NPP is defined as a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law. The allowed NPP must be working in collaboration with or under the supervision of the certifying physician or the physician who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

d. has a continuing need for occupational therapy, if the patient no longer needs any of the therapies above.

2. The patient is or was confined to the home (i.e., homebound). [2]
3. A patient plan of care for furnishing the services has been established by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is has no financial relationship with the Home Health Agency (HHA).

   (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under state law.)
4. The patient services will be or were furnished under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.
5. A face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home.

"Confined to the Home" (Homebound)

Documentation from the certifying physician/acute/post-acute care facility's medical records serves as the basis upon which patient eligibility for the Medicare home health benefit is to be determined. Such documentation includes information that substantiates that the patient is confined to his/her home. In order to be considered "confined to the home" (i.e., homebound), the following two criteria must be met:

1. Criteria-One: The patient must either;
   a) Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence,
   OR
   b) Have a condition such that leaving his or her home is medically contraindicated.

   The patient must meet one of the Criteria One conditions listed above and also meet the two additional requirements defined in Criteria Two below to be considered homebound for purposes of eligibility for the Medicare home health benefit.

2. Criteria-Two:
   a) There must exist a normal inability to leave home; and
   b) Leaving home must require a considerable and taxing effort.

   NOTE: The clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information

[2] As defined in sections 1835(a) and 1814(a) of the Social Security Act.

about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Likewise, occasional absences from the home for nonmedical purposes does not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home: e.g.;

a) Occasional trip to the barber,
b) Walk around the block or a drive,
c) Attendance at a family reunion,
d) Funeral,
e) Graduation, or

Other infrequent or unique event.

§484.60 - Condition of Participation: Care Planning, Coordination of Services, and Quality of Care

Standard: Plan of care.

(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.

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

(i) All pertinent diagnoses;

(ii) The patient's mental, psychosocial, and cognitive status;

(iii) The types of services, supplies, and equipment required;

(iv) The frequency and duration of visits to be made;

(v) Prognosis;

(vi) Rehabilitation potential;

(vii) Functional limitations;

(viii) Activities permitted;

(ix) Nutritional requirements;

(x) All medications and treatments;

(xi) Safety measures to protect against injury;

(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.

(xiii) Patient and caregiver education and training to facilitate timely discharge;

(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;

(xv) Information related to any advanced directives; and

(xvi) Any additional items the HHA or physician may choose to include.

(3) All patient care orders, including verbal orders, must be recorded in the plan of care.

Supporting Documentation

Information from the HHA may be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record regarding the patient for whom the home health services are ordered/certified. When considering incorporation of information from the HHA the following are expected and required:

- Information from the HHA must be corroborated by other medical record entries and align with the time-period in which services were rendered.
- The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).

Completing the Home Health Services Plan of Care / Certification Template does not guarantee eligibility and coverage but does provide guidance in documenting the need for home health services ordered and billed to Medicare by the HHA. This template may be used with the Home Health Services F2F Encounter Template.

Note: If the Home Health Services Plan of Care / Certification Template is used:

1) CDEs in black Calibri are required
2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
3) CDEs in blue Times New Roman are recommended but not required
4) CDEs in purple Tahoma are required for certification and, where noted, for recertification

Version R2.0

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Home Health Plan of Care / Certification

Patient information

Last name: _____ First name: _____ MI: ___

DOB (MM/DD/YYYY): _____ Gender: ___M ___F ___Other Medicare ID:_____

F2F evaluation information

Date of F2F visit (MM/DD/YYYY):_____

Other relevant information

Patient HI Claim No: _____ Medical Record Number: _____

Initial start of care date (MM/DD/YYYY): _____

For recertification: start/end of this episode of care (MM/DD/YYYY): _____/_____

Advanced Directives: _____ Yes _____ No *If yes, describe:* _____

_____

Pertinent diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)

ICD-10-CM	Description	Start date	Status

Relevant procedures (e.g. surgical) (include code from ICD-10-PCS, HCPCS, CPT when available)

Code	Description	Date Performed

Pertinent medications (Status: N=New, A=Active, C=Changed, D=Discontinued) (include RxNorm if known)

RxNorm	Description	Dose	Frequency	Route	Status

Allergies (all) (include RxNorm for medication allergies when known)

RxNorm	Description	RxNorm	Description

Functional assessment:

Functional limitations (check all that apply): ____ Amputation, ____ Bowel/bladder (Incontinence),

____ Contracture, ___ Hearing, ___ Paralysis, ___ Endurance, ___ Speech, ____ Legally blind,

____ Dyspnea with minimal exertion, ___ Angina with minimal exertion or at rest,

____ CVA/hemiparalysis/paralysis/dysphonia, ___ Confined to wheelchair, ____Fall risk

Other functional limitations: _____

Activities permitted (check all that apply): ___ Complete bedrest, ____ Bedrest BRP, ___ Up as tolerated,

____Transfer bed/chair, ____ Partial weight bearing, ____ Independent at home, ___ Crutches, ___ Cane,

____ Wheelchair, ____ Walker, ___ No restrictions

Other activities permitted: _____

Mental status (check all that apply) ____ Oriented, ___ Comatose, ___ Forgetful, ____ Depressed,

____ Disoriented, ____ Lethargic, ____ Agitated

Other mental, psychosocial, and cognitive status observations: _____

_____

_____

DME and supplies: _____

_____

Safety measures: _____

_____

Nutritional requirements: _____

_____

Prognosis: ___ Poor, ____ Guarded, __ Fair, ____ Good, ___ Excellent

Additional clarification: _____

_____

Description of risk for emergency department visits and hospital readmission and all necessary interventions to address risk: _____

_____

_____

_____

Patient and caregiver education and training to facilitate timely discharge: _____

_____

_____

_____

Patient-specific interventions and education: measurable outcomes, goals and status identified by the HHA and patient. Status: Proposed, Accepted, Planned, In Progress, On Target, Ahead of Target, Behind Target, Sustaining, Achieved, On Hold, Cancelled, Rejected

Intervention/Education	Measurable Outcomes /Goals	Status

Orders (may be satisfied with an attached, signed order template)

Intermittent skilled nursing services (*complete all that are required*)

Administration of medications	*Frequency:*_____	*Duration:*_____
Tube feeding	*Frequency:*_____	*Duration:*_____
Wound care	*Frequency:*_____	*Duration:*_____
Catheters	*Frequency:*_____	*Duration:*_____
Ostomy care	*Frequency:*_____	*Duration:*_____
NG and tracheostomy aspiration/care	*Frequency:*_____	*Duration:*_____
Psychiatric evaluation and therapy	*Frequency:*_____	*Duration:*_____
Teaching/training	*Frequency:*_____	*Duration:*_____
Observe/assess	*Frequency:*_____	*Duration:*_____
Complex care plan management	*Frequency:*_____	*Duration:*_____
Rehabilitation nursing	*Frequency:*_____	*Duration:*_____
Other: _____	*Frequency:*_____	*Duration:*_____
Other: _____	*Frequency:*_____	*Duration:*_____

Justification and signature if the patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan or complex care plan management):

_____

_____

_____ *Physician's Signature:* _____

Therapy services *(complete all that are required)*

Physical therapy

Restore patient function	_____	
Perform maintenance therapy	_____	
Therapeutic exercises	*Frequency:*_____	*Duration:*_____
Gait and balance training	*Frequency:*_____	*Duration:*_____
ADL training	*Frequency:*_____	*Duration:*_____
Other: _____	*Frequency:*_____	*Duration:*_____

Occupational therapy

Restore patient function	_____	
Perform maintenance therapy	_____	
Therapeutic exercises	*Frequency:*_____	*Duration:*_____
ADL training	*Frequency:*_____	*Duration:*_____
Other: _____	*Frequency:*_____	*Duration:*_____

Speech-language pathology

Restore language function _____

Restore cognitive function _____

Swallowing *Frequency:*_____ *Duration:*_____

Perform maintenance therapy *Frequency:*_____ *Duration:*_____

Other: _____ *Frequency:*_____ *Duration:*_____

Other Services

Home health aide services *Frequency:*_____ *Duration:*_____

Medical social services *Frequency:*_____ *Duration:*_____

Verbal Orders

Date/time	*Order*	*Taken by*

Frequency, Duration and Purpose of Visits:

Frequency	Duration	Purpose

Additional Items from the HHA and/or physician: _____

Rehabilitation potential

Service/Intervention	Rehabilitation potential

Discharge plans _____

_____

_____

_____

Communicated to primary care physician:

Provider name _____ Date: _____ By: _____

Preparer signature: _____

Last name:_____First name: _____MI:___Suffix:_____

Date (MM/DD/YYYY): _____

Signature, Name, Date and NPI of physician signing the POC/Certification:

If this is a subsequent episode:

How much longer will skilled services be needed? _____

I certify that this patient is confined to his/her home (as outlined in section 30.1.1 in Chapter 7 of the Medicare Benefit Policy Manual (Pub. 100-02)) 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. The patient had a face-to-face encounter with an allowed provider type and the encounter was related to the primary reason for home health care.

I authenticate that the verbal orders recorded above are accurate.

Signature: _____

Last name:_____First name: _____MI:____Suffix:_____

Date (MM/DD/YYYY): _____ NPI:_____

Date physician signed POC was received by the HHA (MM/DD/YYYY): _____

Revisions of the POC communicated to:

Role	*Name*	*Date*	*By*
Patient/Caregiver			
Certifying Provider			
Ordering Provider			
Ordering Provider			
Ordering Provider			