APPENDIX B
MEDICAID INSTRUCTIONS FOR CMS FORM 485 – PLAN OF CARE

ITEM 1 – PATIENT'S HIC NUMBER

For Medicaid agencies, enter the patient's Medicaid number.

ITEM 2 – START OF CARE DATE (SOC)

This is the date service originally began. This date will remain the same on subsequent plans of care as long as the reason(s) for providing home health care remains the same.

ITEM 3 – CERTIFICATION PERIOD

This identifies the period covered by the plan of care. Enter the six-digit month, day and year, i.e., MMDDYY

FROM DATE

- The first day this POC covers includes this day.
- On the initial certification, the "FROM" date will be the same as start of care date.

TO DATE

- This is the end of the certification. The "TO" date is the last day of the plan of care.
- The "TO" date can include up to, but never exceed, 60 calendar days.
- On subsequent recertifications the next sequential "FROM" date will be the day after the "TO" date on the previous plan of care.

ITEM 4 – MEDICAL RECORD NUMBER

No entry needed.

ITEM 5 – PROVIDER NUMBER

Enter the provider number assigned by Medicaid. This number is comprised of nine digits.

ITEM 6 – PATIENT'S NAME AND ADDRESS

Enter the recipient's last name, first name, and middle initial as shown on the recipient's Medicaid eligibility file. List the address where care is being rendered.

ITEM 7 – PROVIDER'S NAME AND ADDRESS

Enter your agency's name and address.

ITEM 8 – DATE OF BIRTH

Enter the recipient's date of birth in six-digit format, i.e., MMDDYY.

ITEM 9 – SEX

Check the appropriate box.

M – Male F – Female

ITEM 10 – MEDICATIONS

Enter all medications including over-the-counter drugs.

Enter dosage, frequency and route of administration.

Enter an "N" after the medication(s) that are "new" orders for the current certification period.

Enter a "C" after the medication(s) that are "change" orders either in dose, frequency or route of administration for the current certification period.

(New or changed medications indicate and support changes or exacerbations in the recipient's condition that may warrant additional or continuing home health services.)

Note: N = new medication within last 30 days.
C = changed medication (dosage, frequency, or route of administration) within last 60 days.

ITEM 11 – PRINCIPAL DIAGNOSIS

Enter a valid ICD-9 code which best describes the principal reason for home health services. The code is the full ICD-9-CM diagnosis code including all digits.

If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

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 plan.

Enter the date of onset or exacerbation in six-digit format (MMDDYY).

Indicate if the diagnosis is a new onset ("O") or an exacerbation ("E") of a pre-existing or chronic condition by placing an "O" or an "E" after the diagnosis date.

If the diagnosis is neither new nor an exacerbation or flare-up of a condition, enter the original date of onset of the condition.

Diagnosis date does not refer to dates of the certification period on the plan of care.

ITEM 12 – SURGICAL PROCEDURE, DATE and ICD-9-CM Code

Enter a valid ICD-9-CM surgical code and date of the surgical procedure. At a minimum, the month and year should be present for date of surgery.

This entry is only necessary if relevant to services being rendered or if the surgical procedure was within the last six months.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 13 – OTHER PERTINENT DIAGNOSES

Enter all pertinent diagnoses relevant to the care rendered. Place in order of seriousness to justify the discipline and services being rendered.

Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or developed subsequently.

Enter the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. Enter the date in MMDDYY format.

ITEM 14 – DME AND SUPPLIES

List supplies and equipment needed for care.

ITEM 15 – SAFETY MEASURES

Enter the physician's instructions for safety measures or those identified by the home health agency.

ITEM 16 – NUTRITIONAL REQUIREMENTS

Enter the physician's orders for the diet including:

- Therapeutic diets;
- Specific dietary requirements; and
- Fluid restrictions or requirements.

Total parenteral nutrition (TPN) can be listed under this item or under medications.

ITEM 17 – ALLERGIES

Enter medicine allergies or other allergies or "NKA."

ITEM 18A – FUNCTIONAL LIMITATIONS

Check current limitations as assessed by the physician or home health agency. If "other" is checked, provide detail below other or in an addendum to the POC.

ITEM 18B – ACTIVITIES PERMITTED

Check all activities allowed by physician. If "Other" is checked, a narrative explanation is required.

ITEM 19 – MENTAL STATUS

Check the most appropriate blocks that describe the patient's mental status. If "Other" is checked, specify here.

ITEM 20 – PROGNOSIS

Check the box that specifies the most appropriate prognosis for the patient.

ITEM 21 – ORDERS FOR DISCIPLINE AND TREATMENTS

List the frequency and duration of visits for each discipline.

List all the services and treatments to be provided by each discipline.

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.

Note: If this field incorporates the physician treatment order (initial or continuation), it must include the requirements for physician treatment orders listed in Chapter 2 of the Home Health Services Coverage and Limitations Handbook.

ITEM 22 – GOALS/REHABILITATION POTENTIAL/DISCHARGE PLANS

Enter the physician's description of achievable goals and the patient's ability to meet these goals.

Address discharge plans, including plans for care after discharge.

Rehabilitation potential should include the expected health outcomes and the patient's ability to achieve goals and estimate of time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond and include more than words "Fair" or "Poor".

ITEM 23 – NURSE'S SIGNATURE AND DATE OF VERBAL START OF CARE

This field identifies the person who spoke with the attending physician and received verbal authorization to either begin or continue services. Enter the date the verbal order was received. This date may precede the SOC date in Field 2 and may precede the "From" date in Field 3

ITEM 24 – PHYSICIAN'S NAME AND ADDRESS

Enter the name and address of the attending physician that established the plan of care.

ITEM 25 – DATE HHA RECEIVED SIGNED POC

Enter the date the agency received the signed, but *not dated,* POC. Enter "N/A" if Item 27 is completed.

It is recommended that agencies date stamp every plan of care upon return from the physician.

ITEM 26 – PHYSICIAN CERTIFICATION STATEMENT

No entry needed.

Medicaid Instructions for CMS Form 485 – Plan of Care, continued

ITEM 27 – ATTENDING PHYSICIAN'S SIGNATURE AND DATE SIGNED

The form must be signed prior to submission of prior authorization request. If a rubber stamp signature is used, it must be initialed by the physician.

Faxed signatures are acceptable; however, the physician must retain the plan with his original signature in the recipient's medical record. The home health agency is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The plan of care may be signed by another physician who is authorized by the attending physician to care for his or her patients in his or her absence, i.e., partnership agreement.

Do not pre-date or write the date in this field. If the physician does not date his/her signature, leave it blank and document in Item 25.

ITEM 28 – ANTI-FRAUD STATEMENT