Form CMS-485, "Home Health Certification and Plan of Care"

Completion of Form CMS-485, Home Health Certification and Plan of Care.--Form CMS-485 meets the regulatory requirements (State and Federal) for both the physician's home health plan of care and home health certification and recertification requirements.

Complete the following:

1. Patient's HICN.—**Omit**

2. Start of Care Date.--Enter the 6 digit month, day, year on which covered home health services began, i.e., MMDDYY (e.g., 101593). The start of care (SOC) date is the first Medicare billable visit if individual is dually eligible for Medicare/Medicaid. If individual is eligible for Medicaid only, SOC is the first Medicaid billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health care may be suspended and later resumed under the same start of care date in accordance with your internal procedures.

3. Certification Period.--Enter the 2 digit month, day, year, MMDDYY (e.g., 101593- 121593), which identifies the period covered by the physician's plan of care. The "From" date for the initial certification must match the start of care date. The "To" date can be up to, but never exceed, two calendar months and mathematically never exceed 62 days. Always repeat the "To" date on a subsequent recertification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

   EXAMPLE: Initial certification "From" date 101593
   Initial certification "To" date 121593
   Recertification "From" date 121593
   Recertification "To" date 021594

4. Medical Record Number.—**Omit**

5. Provider Number.-- **Omit**

6. Patient's Name --Enter the patient's last name, first name, and middle initial as shown on the health insurance card. **Omit address**

7. Provider's Name--Enter your name and/or branch office (if applicable). **Omit address and telephone number.**

8. Date of Birth.— **Omit**

9. Sex.--**Omit**.

10. Medications: Dose/Frequency/Route.--Enter all physicians orders for all medications, including the dosage, frequency, and route of administration for each.
    - Use an Addendum for drugs which cannot be listed on the plan of treatment.
    - Use the letter "N" after the medication(s) which are "new" orders.
    - Use the letter "C" after the medication(s) which are "change" orders either in dose, frequency, or route of administration.

    "New" orders refer to medications which the patient has not taken recently, i.e., within the last 30 days. "Change" orders for medications 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.-Enter the principal diagnosis on all CMS-485 forms. The principal diagnosis is the diagnosis most related to the current plan of treatment. It may or may not be related to the patient's most recent hospital stay, but must relate to the services you rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services.

    Enter the appropriate ICD-9-CM code in the space provided. The code must be the full ICD-9-CM diagnosis code including all digits. V codes are acceptable as both primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, do not use the V code when the acute diagnosis code is more specific to the exact nature of the patient's condition.

    EXAMPLES:
    Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). Use 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture.

    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 (V 55.3). Use V 55.3 as the primary diagnosis since it is more specific to the nature of the 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 of care.

    List the actual medical diagnostic term next to the ICD-9-CM code. Do not describe in narrative format any symptoms or explanations. Do not use surgical procedure codes.
    The date is always represented by six digits (MMDDYY); if the exact day is not known, use 00. The date of onset is specific to the medical reason for home health care services. If a condition is chronic or long term in nature, use the date of exacerbation. Use one or the other, not both. Always use the latest date. Enter all dates as close as possible to the actual date, to the best of your knowledge.

12. Surgical Procedure, Date, ICD-9-CM Code.--Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in Item 11 is "Fractured Left Hip", note the ICD-9-CM Code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 100293). If a surgical procedure was not performed or is not relevant to the plan of care, do not leave the box

blank. Enter N/A. Use an addendum for additional relevant surgical procedures. At a minimum, the month and year must be present for the date of surgery. Use 00 if the day is unknown.

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 plan of care was established or which developed subsequently. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care. These diagnoses can be changed to reflect changes in the patient's condition.

    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. If there are more than four pertinent diagnoses, use an addendum to list them. Enter N/A if there are no pertinent secondary 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 the date of onset or exacerbation 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 nonroutine supplies must be specifically ordered by the physician or the physician's order for services must require the use of the specific supplies. Enter in this item, nonroutine supplies that you are 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 the use of nonroutine supplies which would vary by patient. Therefore, list the nonroutine supplies.

    If you use a commonly used commercially packaged kit, you are not required to list the individual components. However, if there is a question of cost or content, the intermediary can request a breakdown of kit components.

    List DME ordered by the physician that will be billed to Medicare and Medicaid. Enter N/A if no supplies or DME are billed.

15. Safety Measures.--Enter the physician's instructions for safety measures.

16. Nutritional Requirements.--Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Record fluid needs or restrictions. Total Parenteral Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications.

17. Allergies.--Enter medications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, iodine). "No known allergies" may be an appropriate response.

18A. Functional Limitations.--Check all items which describe the patient's current limitations as assessed by the physician and you.

18B. Activities Permitted.--Check the activity(ies) which the physician allows and/or for which physician orders are present.

19. Mental Status.--Check the block(s) most appropriate to describe the patient's mental status. If you check "Other", specify the conditions.

20. Prognosis.--Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good, or excellent.

21. Orders for Discipline and Treatments (Specify amt/freq/dura).--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: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), or home health aid (AIDE).

EXAMPLE OF PHYSICIAN'S ORDERS: Certification period is from 101593 to 121593.

OT - Eval., ADL training, fine motor coordination 3x/wk x 6 wks
ST - Eval., speech articulation disorder treatment 3x/wk x 4 wks
SN - Skilled observation and assessment of C/P and neuro status
instruct meds and diet/hydration, instruct 3x/wk x 2 wks
AIDE - Assist with personal care, catheter care 3x/wk x 9 wks

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 for heat, sound, cold, and electronic stimulation.

EXAMPLE:

PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2 wks
PRN visits may be ordered on a plan of care 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 must be specified. Open-ended, unqualified PRN visits do not constitute physician orders since neither their nature nor their frequency is specified.

EXAMPLE:

Skilled nursing visits 1xmx2m for Foley change and PRNx2 for emergency Foley irrigations and/or changes.
Skilled nursing visits 1xmx2m to draw blood sugar and PRNx2 to draw emergency blood sugar if blood sugar level is above 400.

22. Goals/Rehabilitation Potential/Discharge Plans.--Enter information which 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 ambulation 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.
- Ability to demonstrate correct insulin preparation and administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone are not acceptable. Add descriptors.

EXAMPLE:

Rehabilitation potential 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, be specific as to the goals and when the need for daily care is expected to end.

EXAMPLE:

Granulation of wound with daily wound care is expected to be achieved in 4 weeks. Skilled nursing visits will be decreased to 3 x week at that time.

Discharge plans include a statement of where, or how, the patient will be cared for once home health services are not provided.

24. Physician's Name --Print the physician's name. **Omit address.** The attending physician is the physician who establishes the plan of care and who certifies and recertifies the medical necessity of the visits and/or services. 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 care or certify or recertify the need for home health services. (See §234.6 for information about physician certification/recertification.)

25. Date HHA Received Signed POC.--Enter the date you received the signed POC from the attending/referring physician. Enter N/A if Item 27 (DATE) is completed.

26. Physician Certification.--This statement serves to verify that the physician has reviewed the plan of care and certifies to the need for the services.

27. Attending Physician's Signature and Date Signed.-- Do not predate the orders for the physician, nor write the date in this field. If the physician left it blank, enter the date you received the signed POC under Item 25. Do not enter "N/A." Submit an unsigned copy of the CMS-485. Retain the signed copy.

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