OASIS SCORING GUIDE

General scoring considerations:

- Read answers from the bottom up, with lowest (most dependent) score first and work up to the more independent scores.
- Ask patient to demonstrate the activity, score their item based on their performance prior to any skilled instructions.
  - "show me how you get in and out of bed", "show me how you transfer get on and off of the toilet"
- Use the word 'Safely' after every score. Can the patient do the activity safely?
- If an assistive device is not available during the assessment, we cannot assume safety.
- Start with scoring mobility (M1860) as it may impact other functional scores
- When an OASIS item refers to **assistance**, this means **assistance** from another person. **Assistance refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.**

M Score Functional Items		Considerations
M1242	**Frequency of Pain Interfering** with patient's activity or movement	*Assess both verbal and non-verbal signs ***Does pain impact movement/ability?** *Is patient taking pain medications *If patient is pain free by limiting activity, score as having pain interfering with activity/movement
0	Patient has no pain	
1	Patient has pain that does not interfere with activity or movement	
2	Less often than daily	
3	Daily, but not constantly	
4	All of the time	
M1400	When is patient dyspneic or noticeably **Short of Breath**?	*Need to monitor from start to the end of the visit *SOB may occur later in assessment *Subjective interviewing – what makes you breathless? *Stairs – **observe** up and down stairs *Supplemental O2 – score based on patient's **actual use** of O2 in the home, not on Provider's oxygen order
0	No shortness of breath	
1	When walking more than 20 feet, climbing stairs	
2	With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)	
3	With minimal exertion (for example, while eating, talking or performing other ADLs) or with agitation	
4	All of the time	
M1800	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care)	*Note location of items and ease of access to them *Observe washing hands and/or face ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.	
1	Grooming utensils must be placed within reach before able to complete grooming activities.	
2	Someone must assist the patient to groom self.	
3	Patient depends entirely upon someone else for grooming needs	
M1810	Current **Ability to Dress <u>Upper</u> Body** safely (with/without dressing aids) including undergarments, pullovers, front – opening shirts/blouses, managing zippers, buttons, snaps.	*Identify **safe** ability to dress and undress above the waist in what is **routinely worn** *Includes clothing "fasteners", orthotics, prosthetics, elastic supportive wraps *Includes the **need for set up** ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to get clothes out of closets and drawers, put them on/remove from the upper body without assist	
1	Able to dress upper body without assist if clothing is laid out or handed to patient	
2	Someone must help patient put on upper body clothing	
3	Patient depends entirely on another person to dress the upper body	
M1820	Current **Ability to Dress <u>Lower</u> Body** safely (with/without dressing aides) including undergarments, slacks, socks, nylons, shoes.	*Identify **safe** ability to dress and undress below the waist in what is **routinely worn** *Include the **need for set up** *Consider each dressing article and footwear as an individual task ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to obtain, put on, and remove clothing and shoes without assist	
1	Able to dress lower body without assist if clothing/shoes are laid out or handed to patient	
2	Someone must help the patient put on undergarments, slacks, socks, nylons, and shoes	
3	Patient depends entirely on another person to dress lower body	
M1830	**Bathing:** Current ability to wash entire body safely. Excludes grooming (washing face, washing hands and shampooing hair).	*Identify **safe** ability to bathe self ***Bathroom location matters** *Shower/tub (0-3) vs. sponge bathers (4-5) *Includes washing the entire body (even back) ***Includes Transfer in/out of tub/shower** *Excludes washing face and hands, drying the body and shampooing hair *Gathering supplies, preparing water not included ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to bathe self in shower or tub independently, including getting in and out of tub/shower	
1	With the use of devices, is able to bathe self in shower or tub independently, including getting in/out of the tub/shower	
2	Able to bathe in shower/tub with intermittent assist of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in/out of the shower or tub, OR (c) for washing difficult to reach areas	
3	Able to participate in bathing self in shower/tub but requires presence of another person throughout the bath for assistance or supervision	
4	Unable to use the shower or tub, but able to bathe self independently with or without the use of devise at the sink, in chair, or on commode	
5	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, bedside chair, or on commode with the assistance or supervision of another person	
6	Unable to participate effectively in bathing and is bathed totally by another person	

M1840	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off the toilet/commode.	*Identify **safe** ability to get on and off a toilet or bedside commode ***Includes getting to and from the toilet** *Use of an **assistive device does not lower the code** ***Need to consider if they have the correct equipment *Codes very by method (toilet, commode, bedpan) ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to get to and from the toilet and transfer independently with or without a device	
1	When reminded, assisted or supervised by another person, able to get to and from the toilet and transfer	
2	Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)	
3	Unable to get to and from the toilet or bedside commode, but is able to use a bedpan/urinal independently	
4	Is totally dependent in toileting	
M1845	**Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, including cleaning area around stoma, but not managing equipment.	***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc. *Take physical impairments into account (limited ROM, impaired balance) *take emotional/cognitive/behavioral impairments into account (memory deficits, fear) *Account for **environmental barriers**
0	Able to manage toileting hygiene and clothing management without assistance.	
1	Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.	
2	Someone must help the patient to maintain toileting hygiene and/or adjust clothing.	
3	Patient depends entirely upon another person to maintain toileting hygiene.	
M1850	**Transferring:** Current ability to move safely from bed to chair, ability to turn and position self in bed if patient is bedfast.	*Identifies **safe** ability to transfer from one surface to another and back ***Transfer is from bed to chair and back to bed** *Identifies amount of assistance needed ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc. *May include ambulation ***Consider use of assistive device**
0	Able to independently transfer	
1	Able to transfer with minimal human assistance or with use of assistive device	
2	Able to bear weight and pivot during the transfer process, but unable to transfer self	
3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person	
4	Bedfast, unable to transfer, but is able to turn and position self in bed	
5	Bedfast, unable to transfer and is unable to turn and position self	
M1860	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.	*Identifies **safe** ability to walk once standing on **even and uneven surfaces** *Consider use of assistive device ***Type of assistive device matters for scoring** *Does not include the coming to standing to ambulate ***Does include stairs** ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc. *if chairfast – assess for wheelchair mobility
0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device)	
1	With use of a one-handed device (for example, cane, single crutch, hemi-walker) able to independently walk on even and uneven surfaces and negotiate stairs with or without railings	
2	Requires use of a two-handed device (for example walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces	
3	Able to walk only with the supervision or assistance of another person at all times	
4	Chairfast, unable to ambulate but is able to wheel self independently	
5	Chairfast, unable to ambulate and is unable to wheel self	
6	Bedfast, unable to ambulate or be up in a chair	
M1870	**Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the foot to be eaten.	*Consider dentition and oral condition *Verify patient reported information with caregiver ***Assistance** refers to any kind of direct human intervention; verbal cues, supervision, contact guard, hands on, etc.
0	Able to independently feed self	
1	Able to feed self independently but requires: (a) meal set-up; OR (b) intermittent assistance or supervision from another person; OR (c) a liquid, pureed or ground meat diet.	
2	Unable to feed self and must be assisted or supervised throughout the meal/snack.	
3	Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy	
4	Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy	
5	Unable to take in nutrients orally or by tube feeding	
M2020	**Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**	*Identify patient's current ability to prepare all oral meds **reliably and safely** including **administration** of the **correct does** at the **correct time** at the **appropriate time and interval.** *Consider Oral Medications only *Excludes injectables and IV medications ***Assessing ability, NOT willingness or compliance** ***For ALFs where meds are dispensed by default, be sure to score to patient's **ability**
0	Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times	
1	Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart	
2	Able to take medication(s) at the correct times if given reminders by another person at the appropriate times	
3	Unable to take medication unless administered by another person.	
NA	No oral medications prescribed	

HCHB-Admission Tip Tool

1. Sync- Accept-Sync
2. All * will need to be addressed before the assessment can me marked as completed.
3. Menu button at the top right can be used to go and look at medical records for the patients.
4. Do not start appointment until you arrive at the patient's home.
5. Perform general head to toe assessment, complete oasis walk, if appropriate for home care-Review admit papers, have client sign consents electronically and update the paper forms that will left in home
    1. To complete the financial part of consents, go to the Financial Coordination note
    2. Use Teams to submit photos IEP, Vulnerable Adult (MN), any other forms that may be needed to fill out and left in home for client
    3. Use Teams to submit photos of insurance cards
6. Review medication in Point Care against medications in home, call MD about clinically significant drug interactions/omissions/additions- document findings in the medication interaction note.
7. <u>Enter in 1 diagnosis for primary reason for homecare for all types of payers</u>
8. Pathways: Select appropriate pathways for specific client and modify all *.
    1. If therapy was not originally ordered at admission and from assessment the client does need it- select the pathway additional disciplines needed, then select the type of therapy. Then in the calendar plot the PT01, OT01, or ST01 so it can be scheduled.
    2. Hospital risk pathway, infection control.
9. Interventions and Goals- all these will need to be addressed. Keep in mind Green on Green (provided/Met) or Red on Red (Not provided- Not applicable to plan of care.
    1. Note: These interventions are only used for the admission visit and will not pull to the POC as orders.
10. Plan of care development tab
    1. Review the Admission coordination note to put in the accurate physician/ verbal SOC
11. Call for verbal click verbal order button in service order. WITHIN 24 HOURs of SOC
12. Calendar will need to be added by tapping and holding to develop the freq
    1. Add in any specific types of visit/supervision, recerts, DC and buddy codes if needed.
13. Add non-skilled services to calendar if applicable
14. Add the # of PRN to the first Saturday of episode. 2 is recommended if applicable.
15. If ordered add paraprofessional care plan (Home Care Aide).
    1. - always add the Stop and Watch task
16. Claim code: it will default to the G0299 for direct skill if that is correct click save, If not select appropriate code for the reason for the visits
17. Assure a good Summary is written in narrative note.
    1. Summary to include detailed history of patient
    2. Summary to specify top focus of care including comorbidities clinician feels may impact the POC and include interventions on POC, outline the reasoning for the need of the skilled need such as knowledge deficits of diseases, medications or treatment's, observation and assessment and/or complex care, etc
    3. Add to narrative what the PRN's would be used for including the reason and the nature of the visits.
18. Sync appointment completed within 24 hours or as soon as verbal order is obtained. All attempts should be made to enter in the VO prior to completing and synching the assessment.
    1. If unable to obtain VO timely; and obtain it after sync was performed. Go to the features section and add in a Note called: Clinical Note. Enter in frequency and then the date/time/who relayed order.

Transfer Tip Tool

1. Once client has been admitted to an inpatient facility for 24 hours.
2. If client is on observation and assessment a transfer is not completed. Client must be identified as an inpatient.
3. As soon as office is notified that client was switched to inpatient, then a transfer process must be done.
4. Hospital Hold coordination note to be added. Fill in all * areas- also if known put in the reason of inpatient stay
5. If there is not a visit for this current week, then an order will need to be added to plot transfer on the calendar RN/PT/OT/ST(44) or 44X for non OASIS patients
6. If a visit is available in Point Care the clinician can accept the visit and then choose the Unexpected Even, then select Transfer to Inpatient Facility.
7. Complete Transfer visit.
8. Most common choice.
    a. 06-Transfer without discharge- the plan will be that client is going to return to home care.
    b. 07- Transfer with Discharge when a client is not going to return to home care.
        i. Example:
        ii. When it is known that client will not return home due to permanent placement of nursing home.
        iii. It is known that the client will remain in an inpatient facility after cert period ending.
9. Transfer summary will auto populate from EMR after completing and sync, which office needs to fax to the inpatient facility where the client is being cared for within 2 business days of the known transfer.
10. If the transfer becomes known after the client is already home- no summary or hold order is needed but Transfer OASIS and Resumption of Care OASIS will still need to be completed.

    NOTE: Do not use a transfer do not use RFA-7 /Transferred to an inpatient facility if:

    A patient dies less than 24 hours after being admitted to an inpatient facility, or,
    A patient dies in the emergency room (ER), or ,
    A patient dies in outpatient surgery or in the care of the recover room after an outpatient surgery
    Effective immediately for the above situation use the RFA-8 Death at Home

Recert Tip Tool

Client Name:	Recert Date:

1. Prior to appt contact PT/OT/ST/MSW to discuss need for recert and assure appropriateness.
2. Recert Visit must be done between day 56-60.
3. Perform general assessment and all * must be addressed
4. Review all Diagnosis associated with Plan of Care- update if necessary
5. Review medication in HCHB against medications in home, call MD about clinically significant drug interactions/omissions/additions- document findings in DRR with date, time and name of person relaying info. Write orders for any medication changes.
6. ADD Calendar for frequency/duration (add non-skilled services if applicable)
    1. Add PRN visits if applicable to the first Saturday of the new episode
7. Review paraprofessional care plan (Aide Care Plan) if applicable and modify in necessary.
8. Add Pathway: each episode a new pathway will be entered.
    1. Select pathways that are still appropriate for services
    2. Hospitalization Risk
9. Document skilled intervention in each interventions and mark as performed or not performed.
10. Call for verbal, verbal order button in Plan of care Development WITHIN 24 HOURs of Recert and by no later than day 60.
    1. Date of Verbal Start of Care orders- defaults to the date of the recert visit- does not need to be changed.
11. Complete documentation in the home other than any collaboration that occurs in 5 -day window. When ready to leave home select either complete if finished with documentation or incomplete if more needs to be done.
12. Sync appointment within 24 hours or as soon as verbal order is obtained.
13. Collaborate between RN CM/PT/OT/ST/MSW to give report and document in Care Coordination note.

No services/orders can be provided without provider signature if a verbal was not obtained.

Note: HHCCN may be needed for a change in frequency is a decrease for a Traditional Medicare case.

V6.2024

Discharge from Agency Tip Tool

Discuss all potential discharges with supervisor <u>prior</u> to discharging

1. Make sure all disciplines are completed- clinician performing discharge assessment IN HOME must be last visit in home.
2. Sync- Accept- Sync
3. Discipline specific (18) assessment will be completed in patients' home
4. Interventions and Goals to be marked appropriately.
5. Assure client was given ≥ 48hrs as evidenced by copy in home or give patient MDCR Non-Coverage for all MC cases-take picture with Teams and send to office, then leave original
6. *WI only-Complete DC notice- take picture with Teams, leave original in home.*
7. In Notes add Discharge Summary and complete in its entirety.
8. Review OASIS Measures-address Red areas in assessment
9. End appointment when assessment is complete and are you are ready to leave home. Patient will need to sign.
10. Complete and Sign assessment, then sync.
11. Your Discharge process has now been completed.

Interpretive Guidelines §484.110(a)(6)

Discharge summaries typically contain the following items: Admission and discharge dates, physician responsible for the home health plan of care, reason for admission to home health, type of services provided and frequency of services, laboratory data, <u>medications the patient is on at the time of discharge</u>, patients discharge condition, patient outcomes in meeting the goals in the plan of care and patient/family post discharge instructions.

Discharge OASIS must be done in client's home. Circumstances beyond our control need to be discussed with the clinical Manager. A discharge OASIS is still required but only the "M" questions based on your last home visits and can coordinate with other clinicians that have seen client in last 4 days prior to DC. Document why and from what documentation was this paper discharge completed.

Discharge OASIS must be done no later than 2 days from the client's actual discharge date. (M0090 date assessment completed should not be greater than 2 days from M0906 discharge date)
NOTE: If a transfer was already completed and client did not return home-no further actions need to be taken by clinician- office to close chart out

Workshop on writing Frequencies of Services

Objective of this training is to have clinicians become competent in writing frequencies and being able to plot them on a calendar.

1. **Skilled nursing 2wk2 effective 6/22:**

2017				JUNE		
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

www.free-printable-calendar.net

Agency work week is from Sunday to Saturday

2. **Skilled nursing 1wk1,2wk2,1wk2 effective June 1st:**

2017				JUNE		
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

www.free-printable-calendar.net

3. **Skilled nurse 2wk1,1wk3 effective June 1st:**

2017				JUNE		
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

www.free-printable-calendar.net

4. **Skilled nursing 3wk1, 2wk2 effective June 2nd:**

2017				JUNE		
SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

www.free-printable-calendar.net

(this is a trick question- the order should have been written 1wk1, 3wk1,2wk2. You need to look at the week ending and see make sure you are writing properly.)

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

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.

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

Form Approved
OMB No. 0938-0357

ADDENDUM TO: ☐ PLAN OF TREATMENT ☐ MEDICAL UPDATE

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. Item No.	

9. Signature of Physician	10. Date

11. Optional Name/Signature of Nurse/Therapist	12. Date

Drug Regimen Review process for Orientation

Process Steps

1. Clinician will go over DRR G536 process in New hire orientation.
2. Clinician will go into a test client and add a new medication, change a medication, discontinue a medication and strike out a medication.
3. Clinician will enter in an order with a medication change. Adding any high risk medication pathways if needed
4. Clinician will review where the interactions checker in a test client.
5. New Hire will go over the pill bottle work shop for Joe Schmoe with clinical manager.
6. Clinical Manager/designee will go out on home visit with clinician and complete the reconciliation and ensure competency.

Work shop of Medications Reconciliation

Objective: To train clinicians to do a thorough medication reconciliation with the use of sample medication list and pill bottles.

Scenario: There was a Aveanna Health that was on service and then was transferred into the hospital. Client is now discharged home with a discharge medication list and the RN must do a complete medication reconciliation and a Drug regimen review (DRR).

1. Hand out the Patient medication list, Aveanna Hospital DC list along with the medication bottles with the fake labels on them.
2. Clinician should reconcile the medication to these 2 list.
3. Give the Aveanna Provider Clinic list once reconciliation was completed.
4. Go over problems and concerns noted on the 3 list and discuss what steps should be taken to resolve medication issues.
5. Look at interactions print out from PCC for clinically significant issues
6. Go over the Drug Regimen review questions

Order Number:
764944

HOME HEALTH CERTIFICATION AND PLAN OF CARE

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
999111111A	3/21/2024	3/21/2024 to 5/19/2024	B1500019614001	N/A

Patient's Name and Address:
JOE ZZZSCHMOE (111)111-1111
123 MAIN ST.
COUNCIL BLUFFS, IA 51503-

Provider's Name, Address and Telephone Number:
HCHB AGENCY14
123 MAIN ST.
COUNCIL BLUFFS, IA 51503-
F: (111)111-1111
P: (111)111-1111

Physician's Name & Address:
MARCIA GARZZZRIS, MD
12345 MEDICAL AVE
COUNCIL BLUFFS, IA 51503

Patient's Date of Birth: 7/24/1947
Patient's Gender: FEMALE
Order Date: 3/21/2024 10:18 AM
Verbal Order: Y
Verbal Date: 3/21/2024
Verbal Time: 12:13 PM

Nurse's Signature and Date of Verbal SOC Where Applicable: (deemed as electronic signature)	Date HHA Received Signed POC
TEST RN 3/19/2024	

Patient's Expressed Goals:
TO BEABLETO WALKTO MAIL BOX

ICD-10
Diagnoses:

Order	Code	Description	Onset or Exacerbation	O/E Date
1	I48.91	UNSPECIFIED ATRIAL FIBRILLATION	EXACERBATION	02/23/2024
2	I10	ESSENTIAL (PRIMARY) HYPERTENSION	EXACERBATION	03/21/2024

Frequency/Duration of Visits:
SN 2WK1,1WK6

Orders of Discipline and Treatments:
SKILLED NURSE TO EVALUATE AND DEVELOP PLAN OF CARE TO BE COUNTERSIGNED BY PHYSICIAN/NP/PA. SKILLED NURSE TO ASSESS/EVALUATE CO-MORBID CONDITIONS INCLUDING DEPRESSION AND HISTORY OF FALLS AND OTHER CONDITIONS THAT PRESENT THEMSELVES DURING THE COURSE OF THIS EPISODE TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. MEDICAL CONDITION REQUIRING SKILLED NURSING FOR SERVICES INCLUDE ATRIAL FIB. NURSING SPECIALIZED SKILLS INCLUDE TEACHING AND TRAINING ON DISEASE MANAGEMENT OF ATRIAL FIB

SKILLED NURSE TO OBSERVE AND ASSESS CARDIOVASCULAR SYSTEM TO IDENTIFY CHANGES AND INTERVENE TO MINIMIZE COMPLICATIONS. SKILLED NURSE TO PROVIDE SKILLED TEACHING RELATED TO ALTERED CARDIOVASCULAR STATUS INCLUDING PATHOPHYSIOLOGY, NUTRITION, MEDICATION REGIMEN, AND PERMITTED ACTIVITIES. MAY PERFORM O2 SATURATION LEVELS PRN FOR SIGNS AND/OR SYMPTOMS OF POSSIBLE RESPIRATORY COMPLICATIONS.

SKILLED NURSE TO PROVIDE SKILLED TEACHING/REINFORCEMENT OF MANAGEMENT OF ATRIAL FIBRILLATION.

SKILLED NURSE TO PROVIDE AND INSTRUCT REGARDING FALL PREVENTION INTERVENTIONS.

SKILLED NURSE TO MONITOR PLAN FOR CURRENT TREATMENT OF DEPRESSION SUCH AS EFFECTS OF MEDICATION AND/OR NEED FOR REFERRAL FOR OTHER TREATMENT.

SKILLED NURSE TO PROVIDE/INSTRUCT REGARDING INTERVENTION(S) TO MONITOR AND MITIGATE PAIN.

PATIENT IS IDENTIFIED AS MODERATE/HIGH RISK FOR HOSPITALIZATIONS. PROVIDE SKILLED OBSERVATION, ASSESSMENT, AND SKILLED TEACHING RELATED TO A FIB. DIAGNOSES/CONDITION/SYMPTOM CAUSING HOSPITALIZATION RISK) DUE TO THE REASONABLE POTENTIAL FOR HOSPITALIZATION. CLINICIAN TO OBSERVE CHANGES IN THE PATIENT'S CONDITION AND REPORT CHANGES TO THE PHYSICIAN FOR POSSIBLE ALTERATION IN THE TREATMENT PLAN OR ADDITIONAL PROCEDURES TO STABILIZE THE PATIENT'S CONDITION.

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ON THIS POC ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON 3/19/2024.

LICENSED PROFESSIONAL TO REPORT VITAL SIGNS FALLING OUTSIDE THE FOLLOWING ESTABLISHED PARAMETERS: TEMP<95>101 PULSE<50>100 RESP<12>24 SYSTOLICBP<90>180 DIASTOLICBP<50>90 PAIN>7 O2SAT<90

Goals/Rehabilitation Potential/Discharge Plans:
A PLAN OF CARE WILL BE ESTABLISHED THAT MEETS THE PATIENT'S NURSING NEEDS AND COUNTERSIGNED BY PHYSICIAN.

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan. I further certify that this patient had a Face-to-Face Encounter performed by a physician or allowed non-physician practitioner that was related to the primary reason the patient requires Home Health services on ___3/19/2024_____.

Attending Physician's Signature and Date Signed	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.

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
999111111A	3/21/2024	3/21/2024 to 5/19/2024	B1500019614001	N/A

Patient's Name	Provider's Name
JOE ZZZSCHMOE	HCHB AGENCY14

Goals/Rehabilitation Potential/Discharge Plans:

CARDIOVASCULAR EXACERBATIONS WILL BE IDENTIFIED PROMPTLY AND INTERVENTIONS INITIATED TO MINIMIZE RISKS.
PATIENT/CAREGIVER WILL VERBALIZE/DEMONSTRATE AN ABILITY TO MANAGE CARDIOVASCULAR DISEASE AS EVIDENCED BY NO UNPLANNED HOSPITALIZATIONS BY 4 WEEKS. ABNORMAL O2 SATURATION LEVELS WILL BE REPORTED TO PHYSICIAN.
PATIENT/CAREGIVER WILL TEACH BACK UNDERSTANDING OF ATRIAL FIBRILLATION/PROGNOSIS, POTENTIAL COMPLICATIONS, CORRELATE SYMPTOMS WITH CAUSATIVE FACTORS, IDENTIFY/INITIATE NECESSARY LIFESTYLE CHANGES AND PARTICIPATE IN CARE BY 6 WEEKS
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE MEASURES TO PREVENT FALLS BY 1 WEEK
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE ABILITY TO PROPERLY MANAGE DEPRESSION BY 1WEEK.
CHANGES IN PATIENT CO-MORBID STATUS WILL BE PROMPTLY IDENTIFIED AND REPORTED TO THE PHYSICIAN. PATIENT/CAREGIVER VERBALIZE/DEMONSTRATE ABILITY TO PROPERLY MANAGE PAIN BY 3 WEEKS.
THE PATIENT WILL REMAIN SAFE IN THE HOME ENVIRONMENT WITHOUT HOSPITALIZATIONS.

Rehab Potential:

GOOD/MARKED IMPROVEMENT IN FUNCTIONAL STATUS IS EXPECTED

DC Plans:

DC TO SELF-CARE UNDER SUPERVISION OF PROVIDER WHEN GOALS ARE MET

DME and Supplies:

DME-GRAB BARS; DME-TUB/SHOWER BENCH; DME-WALKER ; GLOVES

Prognosis:

GOOD

Functional Limitations:

BOWEL/BLADDER (INCONTINENCE); ENDURANCE; AMBULATION

Safety Measures:

ANTICOAGULANT PRECAUTIONS, BLEEDING PRECAUTIONS, ADEQUATE LIGHTING, CLEAR PATHWAYS, EMERGENCY PLAN, FALL PRECAUTIONS, INFECTION CONTROL MEASURES / STANDARD PRECAUTIONS, MEDICATION PRECAUTIONS, PATIENT ASSESSED TO SAFELY SELF-ADMINISTER MEDICATIONS,, SAFETY IN ADL'S, REMOVAL OF THROW RUGS, UNIVERSAL PRECAUTIONS, USE OF ASSISTIVE DEVICES

Activities Permitted:

UP AS TOLERATED; TRANSFER BED/CHAIR; EXERCISES PRESCRIBED; WALKER

Nutritional Requirements:

CARDIAC DIET

Advance Directives:

FULL CODE

Mental Statuses:

ORIENTED

Supporting Documentation for Cognitive Status:

(C1) (QM) (PRA) (M1700) COGNITIVE FUNCTIONING: PATIENT'S CURRENT (DAY OF ASSESSMENT) LEVEL OF ALERTNESS, ORIENTATION, COMPREHENSION, CONCENTRATION, AND IMMEDIATE MEMORY FOR SIMPLE COMMANDS.
1 - REQUIRES PROMPTING (CUING, REPETITION, REMINDERS) ONLY UNDER STRESSFUL OR UNFAMILIAR CONDITIONS.
(QM) (M1710) WHEN CONFUSED (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
0 - NEVER
(QM) (M1720) WHEN ANXIOUS (REPORTED OR OBSERVED) WITHIN THE LAST 14 DAYS:
0 - NONE OF THE TIME
(C1) (QM) (PRA) (M1740) COGNITIVE, BEHAVIORAL, AND PSYCHIATRIC SYMPTOMS THAT ARE DEMONSTRATED AT LEAST ONCE A WEEK (REPORTED OR OBSERVED): (MARK ALL THAT APPLY.)
7 - NONE OF THE ABOVE BEHAVIORS DEMONSTRATED
INDICATE CLIENT'S MENTAL STATUS: (MARK ALL THAT APPLY)
ALERT

Supporting Documentation for Psychosocial Status:

(QM) (M1100B) PATIENT LIVES WITH OTHER PERSON(S) IN THE HOME: WHICH OF THE FOLLOWING BEST DESCRIBES THE PATIENT'S AVAILABILITY OF ASSISTANCE AT THEIR RESIDENCE?
09 - OCCASIONAL / SHORT-TERM ASSISTANCE

Signature of Physician	Date
Optional Name/Signature Of TEST RN	Date 3/19/2024

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
999111111A	3/21/2024	3/21/2024 to 5/19/2024	B1500019614001	N/A

Patient's Name	Provider's Name
JOE ZZZSCHMOE	HCHB AGENCY14

Supporting Documentation for Risk of Hospital Readmission:

(PRA) (M1033) RISK FOR HOSPITALIZATION: WHICH OF THE FOLLOWING SIGNS OR SYMPTOMS CHARACTERIZE THIS PATIENT AS AT RISK FOR HOSPITALIZATION? (MARK ALL THAT APPLY.)

1 - HISTORY OF FALLS (2 OR MORE FALLS - OR ANY FALL WITH AN INJURY - IN THE PAST 12 MONTHS) || 2 - UNINTENTIONAL WEIGHT LOSS OF A TOTAL OF 10 POUNDS OR MORE IN THE PAST 12 MONTHS || 3 - MULTIPLE HOSPITALIZATIONS (2 OR MORE) IN THE PAST 6 MONTHS || 4 - MULTIPLE EMERGENCY DEPARTMENT VISITS (2 OR MORE) IN THE PAST 6 MONTHS

Allergies:

NKA

Signature of Physician	Date
Optional Name/Signature Of TEST RN	Date 3/19/2024

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
999111111A	3/21/2024	3/21/2024 to 5/19/2024	B1500019614001	N/A

Patient's Name	Provider's Name
JOE ZZZSCHMOE	HCHB AGENCY14

Medications:

Medication/ Dose	Frequency	Route	Start Date/ End Date	DC Date	New/ Changed
ASPIRIN 81 MG TABLET,DELAYED RELEASE		ORAL			
1 tablet	*DAILY*				
Reason: HEART HEALTH Instructions: IN AM					
CLOZARIL 200 MG TABLET		ORAL			
400 mg	*3 TIMES DAILY*				
Reason: MOOD Instructions: TAKE BEFORE MEALS					
FLUOXETINE 20 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: DEPRESSION Instructions: TAKE IN MORNING					
ISOSORBIDE DINITRATE 30 MG TABLET		ORAL			
15 mg	*DAILY*				
Reason: CORONARY ARTERY DISEASE Instructions: IN AM					
LISINOPRIL 10 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: HYPERTENSION Instructions: IN AM					
METOPROLOL TARTRATE 50 MG TABLET		ORAL			
100 mg	*DAILY*				
Reason: BLOOD PRESSURE Instructions:					
NAPROXEN 375 MG TABLET		ORAL			
1 tablet	*2 TIMES DAILY*				
Reason: PAIN Instructions:					
OMEPRAZOLE 20 MG CAPSULE,DELAYED RELEASE		ORAL			
1 capsule	*DAILY*				
Reason: STOMACH ACID Instructions:					
TRAMADOL 100 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: PAIN Instructions: TAKE EVENING					
WARFARIN 2.5 MG TABLET		ORAL			
2.5 mg	*AS DIRECTED*				
Reason: ANTICOAGULANTS Instructions: TAKE 2..5 MF TUESDAY AND THURSDAY					
WARFARIN 5 MG TABLET		ORAL			
5 mg	*AS DIRECTED*				
Reason: ANTICOGULANT Instructions: TAKE 5 MG SUNDAY,MONDAY,WEDNESDAY, FRIDAY, SATURDAY					
ZOCOR 20 MG TABLET		ORAL			
1 tablet	*DAILY*				
Reason: CHOLESTEROL Instructions: TAKE AT BEDTIME					

Signature of Physician	Date
Optional Name/Signature Of TEST RN	Date 3/19/2024

Patient's Medicare No.	SOC Date	Certification Period	Medical Record No.	Provider No.
999111111A	3/21/2024	3/21/2024 to 5/19/2024	B1500019614001	N/A

Patient's Name	Provider's Name
JOE ZZZSCHMOE	HCHB AGENCY14

Supporting Documentation for Home Health Eligibility:

STRUCTURAL IMPAIRMENT: SIGNIFICANT DEVIATION(S) OR LOSS IN BODY STRUCTURE (ANATOMICAL PARTS OF THE BODY SUCH AS AN ORGAN, LIMB, OR OTHER COMPONENTS)
STRUCTURES OF THE CARDIOVASCULAR SYSTEM

SPECIFY ADDITIONAL FINDINGS (LIST REASONS TO WHAT IS CAUSING TAXING EFFORT):
PATIENT REQUIRES ANOTHER PERSON TO LEAVE HOME DUE TO MULTIPLE STEPS IN AND OUT OF HOUSE WHEN PATIENT AMBULATES HE MUST SIT DOWN AT LEAST EVERY 10 MINUTES AND CANNOT GO LONG DISTANCES ON A PATIENT HAS SOME PAIN THAT IS DIFFICULT WITH TRANSFERRING SO MANY TANS ON ASSISTANCE CLIENTS ALSO BECOMES EXHAUSTED WHEN ARRIVES BACK AT HOME AND MUST NAP AND NOT BE ABLE TO COMPLETE THE REST OF THEIR DAILY ACTIVITIES OF RIVERS

FUNCTIONAL IMPAIREMENT: SIGNIFICANT DEVIATION(S) OF LOSS IN PHYSIOLOGICAL FUNCTION OF BODY SYSTEMS(INCLUDING PSYCHOLOGICAL).
FUNCTIONS OF THE RESPIRATORY SYSTEM

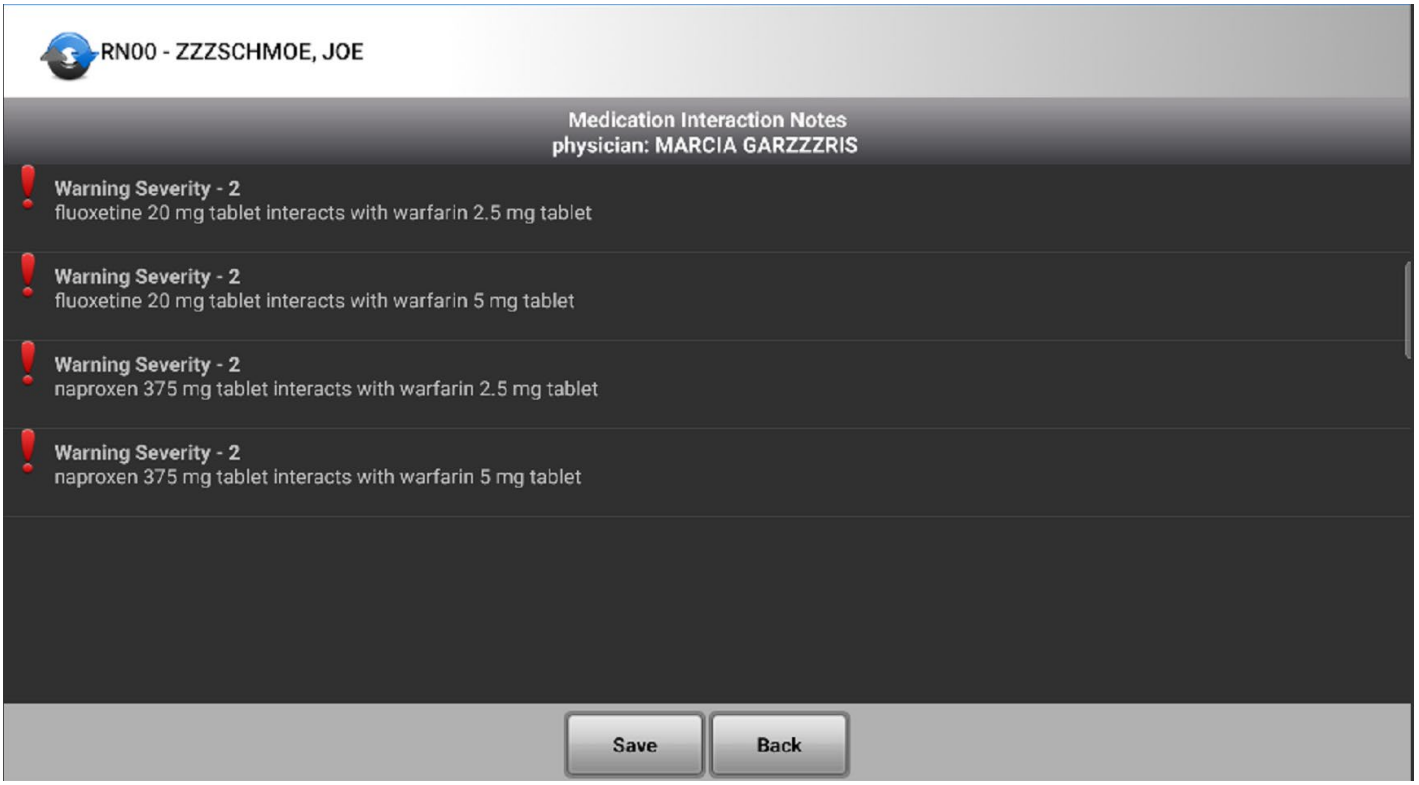
REASONS PATIENT IS HOMEBOUND AND LEAVING HOME REQUIRES SIGNIFICANT AND TAXING EFFORT:
DIFFICULTY TRANSFERRING

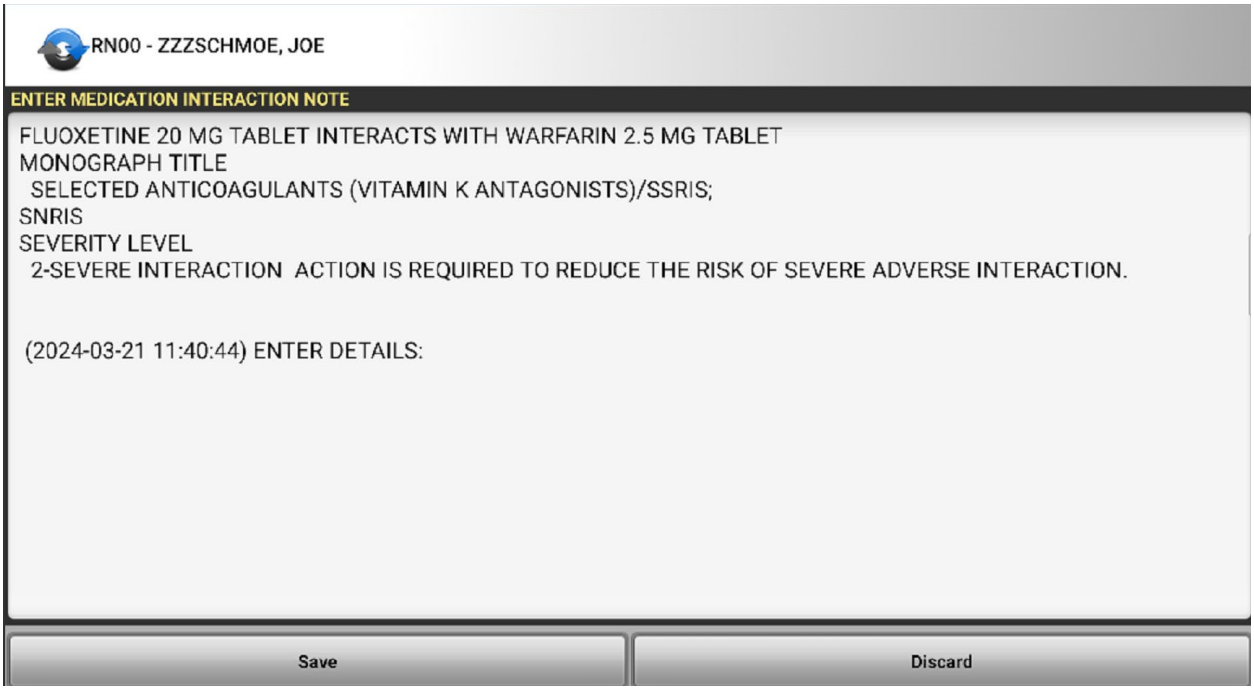
IN CONSIDERATION TO ILLNESS OR INJURY, THE PATIENT IS CONSIDERED HOMEBOUND/CONFINED TO HOME DUE TO: (MARK ALL THAT APPLY)
PATIENT NEEDS AID OF SUPPORTIVE DEVICES - WALKER

ACTIVITY LIMITATIONS AND PARTICIPATION RESTRICTIONS:
COMMUNICATION

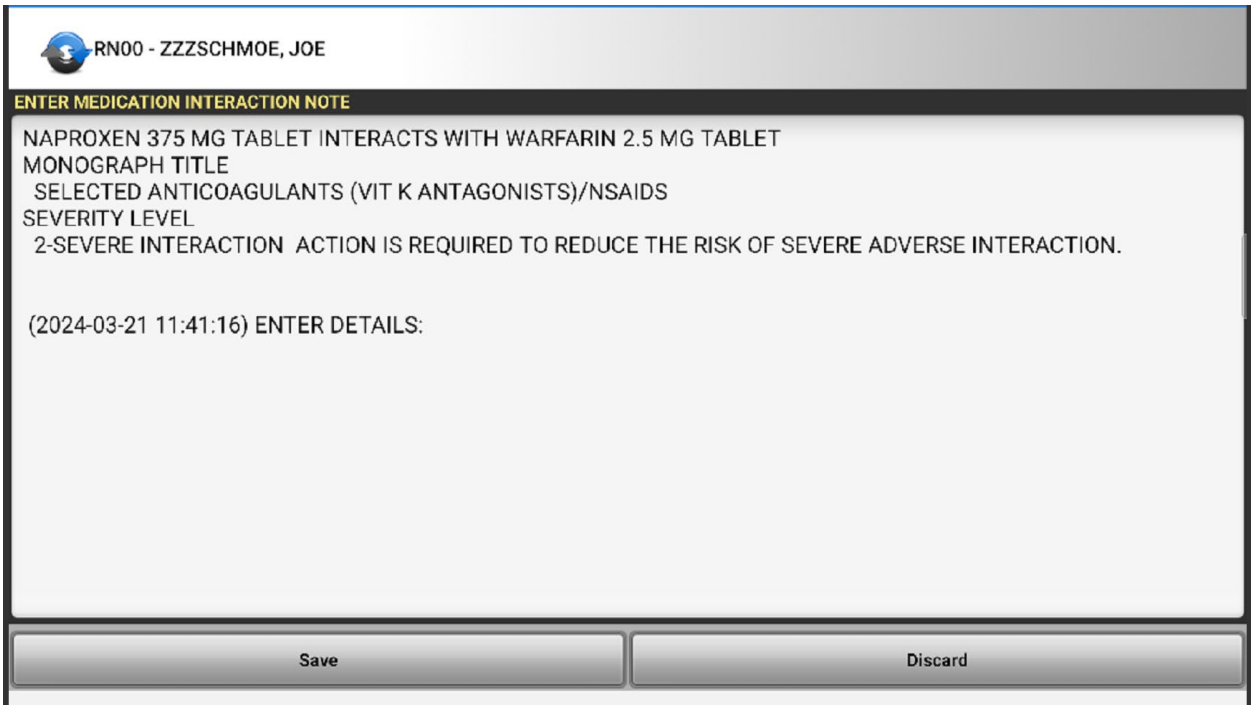
Signature of Physician	Date
Optional Name/Signature Of TEST RN	Date 3/19/2024

Joe Schmoe Interactions





Joe Schmoe Interactions



Order Number: 764945

Printed: 3/21/2024 1:56 PM
Eastern Time Zone

HCHB AGENCY14
123 MAIN ST.
COUNCIL BLUFFS, IA 51503-0831
Phone: (111)111-1111
Fax: (111)111-1111

PHYSICIAN:

MARCIA GARZZZRIS, MD
12345 MEDICAL AVE
COUNCIL BLUFFS, IA 51503

Phone:
Fax:
2nd Physician:
Send to Physician: Y
Verbal Order: N

CLIENT:

ZZZSCHMOE, JOE
123 MAIN ST.
COUNCIL BLUFFS, IA 51503-

SSN: 999-34-9182
DOB: 7/24/1947 **MR#:** B1500019614001
CERT: 3/21/2024 to 5/19/2024
Order Read Back to Physician/Agent of Physician?: Y
ABN Delivered to Patient?: NA

Order Date: 3/21/2024 12:55 PM **Order Type:** PHYSICIAN ORDER

Order Description:
WRITE IN ALL MEDICATIONS THAT WOULD NEED TO HAVE CLARIFYING ORDERS:

ENTERED / TAKEN BY (ELECTRONICALLY SIGNED):	TEST RN	**DATE:**	03/21/2024
APPROVED / PROCESSED BY (ELECTRONICALLY SIGNED):		**DATE:**	
PHYSICIAN SIGNATURE:		**DATE:**	

Aveanna Inpatient Hospital

Patient: Joe Shmoe
DOB: 06/09/56
Admission: 3/13/22
Discharge: 3/21/22

Discharge Medications

Lasix 10mg by mouth every morning po

Tramadol 100mg by mouth every evening po

Lisinopril 10mg by mouth every morning po

Nitroglycerin 0.3mg every 5 min up to 3 times po

Metoprolol 50 mg by mouth every morning po

Warfarin Sodium 5mg by mouth every morning except Wednesdays po

Warfarin Sodium 2.5mg by mouth on Wednesdays po

Isosorbide 15mg by mouth every morning po

Zocor 20mg by mouth every day at bedtime po

Advair Diskus 250/50 Inhale 1 puff BID via inhaler

Aveanna Provider Clinic

Patient: Joe Shmoe
DOB: 06/09/1956

Medication List

Lasix 10mg by mouth every morning PO

Tramadol 100mg by mouth every evening PO

Omeprazole 20mg by mouth every morning PO

Lisinopril 10mg by mouth every morning PO

Nitroglycerin 0.3mg every 5 min up 3 times SL

Metoprolol 100 mg by mouth every morning PO

Naproxen 375mg by mouth twice a day PO

Warfarin Sodium 5mg by mouth every Su, Mon, Wed, Fri, Sat PO

Warfarin Sodium 2.5mg by mouth every Tu, Thur PO

Oxycodone 5mg – 10mg by mouth every 6hrs prn PO

Isosorbide 15mg by mouth every morning PO

Zocor 20mg by mouth every day at bedtime PO

Advair Diskus 250/50 1 puff twice a day via inhalation

aveanna home health

Home Health Consent

Patient Name: _____ **DOB:** _____ **MR#:** _____

Patient Rights and Responsibilities:
I acknowledge I have read and have received a verbal explanation and a written copy of the Client's Rights and Responsibilities under the State and Federal provisions in the Home Care Bill of Rights, and I understand them. I have received a copy of the Aveanna Home Health Admission Booklet containing information regarding its policies and Health Care Directives, the Outcome and Assessment Information Set ("OASIS") rights, agency Administrator's name, and contact information; Discharge, Transfer, and Referral policies; and how to contact local resources. The applicable state home health hotline number, its purpose, and hours of operation have been provided and explained to me. I understand that I have the right to choose my provider of services and acknowledge that I have chosen this agency as my provider of choice for my care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

Consent for Treatment:
I hereby give my permission for authorized personnel of Aveanna Home Health to perform all necessary assessments, procedures, and treatments as prescribed by my physician for the delivery of home health care, including telehealth services. I understand that services provided by telehealth will not replace needed in-person visits as ordered by my physician in my plan of care. I understand that the agency will supervise the services provided. I may refuse treatment or terminate services at any time, and the agency may terminate their services to me as outlined in the Admission Booklet.

I agree and consent to the home care plan and payment as outlined in the Admission Booklet. I understand my initial Plan of Care and subsequent Plans of Care may change based on medically necessary determinations made by my physician. I will be notified by the agency in advance of any change made to my plan of care.

Authorization for Payment:
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payer be made on my behalf to Aveanna Home Health.

If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full, and I have no financial liability. Should service(s) not be covered by Medicare and I wish to receive care or service, the Agency will notify me in writing. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. If I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me, or my supplier and I will be responsible for the total cost.

Patient Name: _____ **DOB:** _____ **MR#:** _____

Patient Financial Responsibility:

Selection	Description	
☐	1. Medicare will pay 100% of authorized visits.	
☐	2. Insurance/Medicare Advantage Plan/Government Plan	
	• Payor:	
	• Estimated Financial Responsibility:	
	Deductible: $ _____	Out of Pocket Max: $ _____
	Deductible Remaining: $ _____	Out of Pocket Remaining: $ _____
	Coinsurance/Copay: $ _____	
	Medicare Secondary Payor: ☐ No, Patient does not have a Medicare Secondary plan. ☐ Yes, Patient has a Medicare Secondary Plan. Primary insurance will be billed first. Any outstanding balance that remains will be billed to Medicare. Patient's estimated financial responsibility will be $0.	
☐	3. Medicaid will pay 100% of authorized visits after spend-down, Spend down $ _____ /month	
☐	4. 100% Private Pay Services Estimated Financial Responsibility: $ _____ /month	

Services	Proposed Frequency	Services	Proposed Frequency
☐ Skilled Nursing		☐ Home Health Aide	
☐ Physical Therapy		☐ Social Worker	
☐ Occupational Therapy		☐ Homemaker	
☐ Speech Therapy			

If I have other insurance, I may be responsible for the co-payment, deductible, and any charges that my insurance will not cover. I will refer to my payer's explanation of benefits for maximum amount that I may be required to pay for services provided to me by Aveanna. I understand that I am responsible for amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency at Aveanna's usual and customary rate at the time the service was provided to me.

Authorization for Release of Information:
I acknowledge receipt of the **Notice of Privacy Practices** and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information (PHI) about me to carry out treatment, payment, or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid, or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing, quality assurance, and risk management; any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies, and any other health care providers in order to initiate treatment.

I agree that the agency may share my PHI with emergency officials or others involved in my care to assist in disaster relief efforts.

Consent to Film or Record:
I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes. This consent includes the recording or filming of my image or voice.

☐ Yes, I consent (default) ☐ Non-standard option: No, I do not consent

Advance Directives:
I have been made aware of my right to make health care decisions for myself in accordance with state law and that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I authorize Aveanna Home Health to receive a copy of my Advance Directive for their records. I understand if a copy of my Advance Directive is **not provided** to Aveanna Home Health within a reasonable period of time, the agency will continue to provide all care as ordered by my physician, which in the event of an adverse event and/or healthcare emergency, includes life sustaining and stabilizing measures consistent with standard and accepted medical practices.

Patient Name: _____ **DOB:** _____ **MR#:** _____

I have read and understand the following policies and/or procedures as described in the Aveanna Home Health Admission Booklet:

1. Rights and Responsibilities
2. Notice of Nondiscrimination
3. Notice of Privacy Practice
4. Discharge, Transfer, Referral and Corresponding Summary
5. Notice of OASIS Rights and Responsibilities
6. High Alert Medication Side Effects
7. Beneficiary and Family Centered Care (BFCC) and Quality Improvement Organizations (QIO) Directory
8. Administrator Notification
9. Patient Individualized Emergency Plan
10. Patient Safety Tips
11. Cover Your Cough
12. *Federally Funded or State Funded Entities Form (AVA-961)
13. *Call Us First Flyer (AVE-1600)
14. *Complaint and Grievance Procedure (AVA-957)

    * = *addendums to the booklet*

Include the following additional forms if applicable:

- ☐ Advance Beneficiary Notice of Noncoverage (ABN) (AVA-026)
- ☐ Authorization for Alternate Communication (AVA-964)
- ☐ Notice of Medicare Non-Coverage (NOMNC) (AVA-027)
- ☐ Home Health Change of Care Notice (HHCCN) (AVA-028)
- ☐ Florida Advance Directives (AVA-960)
- ☐ Florida How to Safely Throw Away Needles At Home (AVA-963)
- ☐ Iowa Bill of Rights Addendum (AVA-935.01)
- ☐ Massachusetts Advance Directives (AVA-962)
- ☐ Minnesota Bill of Rights Addendum (AVA-935.04)
- ☐ Nebraska Bill of Rights Addendum (AVA-935.02)
- ☐ Wisconsin Discharge Transfer Notice (AVA-958)
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

By signing this consent, I acknowledge receipt of the Aveanna Home Health Admission Booklet and confirm my understanding and agreement with its contents. I understand a copy of this consent shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

By signing, I certify that I have received and read the above information. Any questions concerning these policies have been discussed. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges not paid by insurance. A photocopy of this document is as valid as the original. You may achieve a copy of this document upon request.

Document signed electronically, digital signature on file. For reference only.

Chapter 7 and COP's to Review by Section

Chapter 7:

30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:

• Be confined to the home;

• Under the care of a physician;

• Receiving services under a plan of care established and periodically reviewed by a physician;

• Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or

• Have a continuing need for occupational therapy.

For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than

7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed in §§40 and 50.

30.1.1 - Patient Confined to the Home

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. ***Criterion One:***

The patient must either:

- 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

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. ***Criterion Two:***

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

To clarify, in determining whether the patient meets criterion two of the homebound definition, 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 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. Absences attributable to the need to receive health care treatment include, but are not limited to:

• Attendance at adult day centers to receive medical care;

• Ongoing receipt of outpatient kidney dialysis; or

• The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a

religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would 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.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists are listed below.

• A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.

• A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.

• A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence.

• A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (meeting both criteria listed above) more frequently during a short period when the patient has multiple appointments with health care professionals and medical tests in 1 week. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.

• A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain because of the surgery and; therefore, their actions may be restricted by their physician to certain specified and limited activities (such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.).

• A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.

• A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of feebleness and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, SNF, or a rehabilitation center to provide these services on an outpatient basis. (See §50.6.) However, even in these situations, for the services to be covered as home health services the patient must be considered confined to home and meet both criteria listed above.

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the Medicare contractor with the information necessary to establish that the patient is homebound as defined above.

30.4 - Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample)

The patient must need one of the following types of services:

1. Skilled nursing care that is • Reasonable and necessary as defined in §40.1; • Needed on an "intermittent" basis as defined in §40.1.3; and • Not solely needed for venipuncture for the purposes of obtaining blood sample as defined in §40.1.2.13;or

2. Physical therapy as defined in §40.2.2; or

3. Speech-language pathology services as defined in §40.2.3; or

4. Have a continuing need for occupational therapy as defined in §§40.2.4. The patient has a continued need for occupational therapy when: 1. The services which the patient requires meet the definition of "occupational therapy" services of §40.2.4, and 2. The patient's eligibility for home health services has been established by virtue of a prior need for skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), speech-language pathology services, or physical therapy in the current or prior certification period.

EXAMPLE: A patient who is recovering from a cerebrovascular accident (CVA) has an initial plan of care that called for physical therapy, speech-language pathology services, occupational therapy, and home health aide services. In the next certification period, the physician or allowed practitioner orders only occupational therapy and home health aide services because the patient no longer needs the skills of a physical therapist or a speech language pathologist, but needs the services provided by the occupational therapist. The patient's need for occupational therapy qualifies him for home health services, including home health aide services (presuming that all other qualifying criteria are met), because in the prior certification period the beneficiary’s eligibility for home health services was established by virtue of prior needs for physical therapy

and speech-language pathology, and occupational therapy was initiated while the patient still required physical therapy and/or speech language-pathology.

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; “Home Health Agency Billing”, instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient’s achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

• the history and physical exam pertinent to the day’s visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and

• the patient/caregiver’s response to the skilled services provided, and

• the plan for the next visit based on the rationale of prior results,

• a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,

• the complexity of the service to be performed, and

• any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

• Patient tolerated treatment well

• Caregiver instructed in medication management

• Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

EXAMPLE 1:

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown. The documentation must support the severity of the circulatory condition that requires skilled care. The clinical notes for each home health visit should document the patient's skin and circulatory examination as well as the patient and/or caregiver application of the educational principles taught since the last visit. The plan for the next visit should describe the skilled services continuing to be required.

EXAMPLE 2:

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit. The documentation must support the skilled need for the enema, and the plan for future visits based on this information.

EXAMPLE 3:

Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse (as discussed in §30.1 above).

EXAMPLE 4:

A patient with a well-established colostomy absent complications may require assistance changing the colostomy bag because they cannot do it themselves and there is no one else to change the bag. Notwithstanding the need for the routine colostomy care, changing the colostomy bag does not become a skilled nursing service when the nurse provides it.

EXAMPLE 5:

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.

EXAMPLE 6:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. The home health record must document the reason skilled services are required and why the nursing visits are reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE 7:

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient, newly diagnosed, with diabetes mellitus in the home health plan of care. Each visit’s documentation must describe the patient’s progress in this activity.

EXAMPLE 8:

Following a cerebrovascular accident (CVA), a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of care. Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper catheter care would be covered as long as they are reasonable and necessary, although the patient is stable, even if there is an expectation that the care will be needed for a long and indefinite period. However, at every home health visit, the patient’s current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.

EXAMPLE 9:

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. The clinical notes for each home health visit must describe why skilled nursing services were required. The skilled nursing care received by the patient would be covered despite the chronic nature of the illness.

EXAMPLE 10:

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit. The documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal. The skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the documentation and description must support that the needed services required the skills of a nurse.

40.1.2 - Application of the Principles to Skilled Nursing Services

The following discussion of skilled nursing services applies the foregoing principles to specific skilled nursing services about which questions are most frequently raised.

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and/or treatment regimen has stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and

assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the illness or injury where fluctuating

signs and symptoms are part of a longstanding pattern of the patient's condition which has not previously required a change in the prescribed treatment.

EXAMPLE 1:

A patient with atherosclerotic heart disease with congestive heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from newly prescribed medication. Skilled observation is needed to determine whether the new drug regimen should be modified or whether other therapeutic measures should be considered until the patient's clinical condition and/or treatment regimen has stabilized. The clinical notes for each home health visit should reflect the deliberations and their outcome.

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection, (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. For each home health visit, the clinical notes must demonstrate that the skilled observation and monitoring is required.

EXAMPLE 3:

A patient was hospitalized following a heart attack. Following treatment he was discharged home. Because it is not known whether increasing exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated in the patient’s home. The patient’s necessity for skilled observation must be documented at each home health visit until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 4:

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. The patient’s necessity for skilled observation and treatment must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 5:

A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta-blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmia. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized. The patient’s necessity for skilled observation must be documented at each home health visit, until the clinical condition and/or patient's treatment regimen has stabilized.

EXAMPLE 6:

A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 7:

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a continuation of skilled care for a subsequent 60-day certification period, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.1.2.2 - Management and Evaluation of a Patient Care Plan

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful

skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until

nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the period with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the unskilled services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety. For this determination to be made, the home health documentation must describe the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of a registered nurse in order to ensure that essential unskilled care is achieving its purpose. Where visits by a licensed nurse are not needed to observe and assess the effects of the unskilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE 3:

A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a patient whose recovery from a CVA has left him with residual weakness on the left side. The cardiovascular condition is stable and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

40.1.2.3 - Teaching and Training Activities

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are

reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. The reason why the training was unsuccessful should be documented in the record. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

EXAMPLE 1:

A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies. The education is reasonable and necessary to the treatment of the illness or injury, and the teaching services and the patient/caregiver responses must be documented.

EXAMPLE 2:

A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition, to recognize signs and symptoms of adverse reactions to new medications, and to follow the necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing

care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to be taught. The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses. The health record should also describe the reason for the failure of the educational attempts.

EXAMPLE 3:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require re-teaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to re-teach self-administration of the insulin would be reasonable and necessary. The patient's response to teaching must be documented at each home health visit, until the patient has learned how to self-administer.

EXAMPLE 5:

A patient recovering from pneumonia is being sent home requiring I.V. infusion of antibiotics four times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has ordered home health services for a nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention.

EXAMPLE 6:

A spouse who has been taught to perform a dressing change for a post-surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

NOTE: There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities that require the skills of a licensed nurse include, but are not limited to, the following:

1. Teaching the self-administration of injectable medications, or a complex range of medications;

2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;

3. Teaching self-administration of medical gases;

4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;

5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

6. Teaching self-catheterization;

7. Teaching self-administration of gastrostomy or enteral feedings;

8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;

10. Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;

11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;

12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

14. Teaching prosthesis care and gait training;

15. Teaching the use and care of braces, splints and orthotics and associated skin care;

16. Teaching the preparation and maintenance of a therapeutic diet; and

17. Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments)

40.1.2.4 - Administration of Medications

Although drugs and biologicals are specifically excluded from coverage by the statute (§1861(m)(5) of the Act, the services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

A. Injections

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

1. Vitamin B-12 injections are considered specific therapy only for the following conditions:

• Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

• Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome, and

• Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment. More frequent injections would be appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose.

2. Insulin Injections

Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

EXAMPLE: A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional

tremors, and vision loss that causes inability to fill syringes or self-inject insulin. If there weren't an able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

The prefilling of syringes with insulin (or other medication that is self-injected) does not require the skills of a licensed nurse and, therefore, is not considered to be a skilled nursing service. If the patient needs someone only to prefill syringes (and therefore needs no skilled nursing care on an intermittent basis, physical therapy, or speech-language pathology services), the patient, therefore, does not qualify for any Medicare coverage of home health care. Prefilling of syringes for self-administration of insulin or other medications is considered to be assistance with medications that are ordinarily self-administered and is an appropriate home health aide service. (See §50.2.) However, where State law requires that a licensed nurse prefill syringes, a skilled nursing visit to prefill syringes is paid as a skilled nursing visit (if the patient otherwise needs skilled nursing care, physical therapy, or speech-language pathology services), but is not considered to be a skilled nursing service.

B. Oral Medications

The administration of oral medications by a nurse is **not** reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

C. Eye Drops and Topical Ointments

The administration of eye drops and topical ointments **does not** require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the

treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the patient's condition. (See §40.2.1.)

EXAMPLE 1:

A physician has ordered skilled nursing visits to administer eye drops and ointments for a patient with glaucoma. The administration of eye drops and ointments does not require the skills of a nurse. Therefore, the skilled nursing visits cannot be covered as skilled nursing care, notwithstanding the importance of the administration of the drops as ordered.

EXAMPLE 2:

A physician has ordered skilled nursing visits for a patient with a reddened area under the breast. The physician instructs the patient to wash, rinse, and dry the area daily and apply vitamin A and

D ointment. Skilled nursing care is not needed to provide this treatment and related services safely and effectively.

40.1.2.5 - Tube Feedings

Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization. and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services.

40.1.2.6 - Nasopharyngeal and Tracheostomy Aspiration

Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

40.1.2.7 - Catheters

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and

silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to three additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or caregiver reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to report findings and discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury. The need for the skilled services must be documented.

40.1.2.8 -Wound Care

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to

provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. This includes whether wound care is performed via dressing changes, NPWT using conventional DME systems or NPWT using a disposable device. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g., sterile or complex dressings, NPWT, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

• Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;

• Wounds with a drain or T-tube that require shortening or movement of such drains;

• Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;

• Recently debrided ulcers;

• Pressure sores (decubitus ulcers) with the following characteristics:

o There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or

o There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

• Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);

• Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;

• Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);

• Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;

• Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;

• Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1:

A patient has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services. The home health record at each visit must document the need for the skilled nursing services.

EXAMPLE 2:

A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. The home health record at each visit must document the need for the skilled nursing services.

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (see §40.1.2.1) or for skilled teaching of wound care to the patient or the patient's family (see §40.1.2.3). For an example of when wound care is provided separately from the furnishing of NPWT using a disposable device, see §50.4.4.

40.1.2.9 - Ostomy Care

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. The teaching services and the patient/caregiver responses must be documented.

COP’s

G818

§484.80(h)(4) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:

(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;

(iii) Demonstrating competency with assigned tasks;

(iv) Complying with infection prevention and control policies and procedures;

(v) Reporting changes in the patient's condition; and

(vi) Honoring patient rights.

Interpretive Guidelines §484.80(h)(4)

During each supervisory visit the supervising registered nurse, or other appropriate skilled professional, should document his or her evaluation of the HH aide with regard to each of the elements of this standard.

§484.80(h)(4)(ii) "Maintaining an open communication process" means that the aide is able to explain what he or she is going to do with the patient, ask the patient open-ended questions, seek feedback from the patient, and respond to the needs and requests of the patient, representative (if any), caregivers, and family.

G590 §484.60(c)(1) The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Interpretive Guidelines §484.60(c)(1)

For "responsible physician" see §484.60(a)(1).

The signature and date of the review by the responsible physician verifies the interval between plan of care reviews.

The plan of care may include orders for treatment or services received from physicians other than the responsible physician; such orders must be approved by the responsible physician and incorporated into an updated plan of care. In the event of a change in patient condition or needs that suggest outcomes are not being achieved and/or that the patient's plan of care should be altered, the HHA should notify both the responsible physician and the physician(s) associated with the relevant aspect of care.

Changes in physician orders during the plan of care certification period do not automatically restart the timeframe for physician review of the plan of care.

G706

§484.75(b)(1) Ongoing interdisciplinary assessment of the patient;

Interpretive Guidelines §484.75(b)(1)

The term "interdisciplinary" refers to an approach to healthcare that includes a range of health service workers. "Ongoing interdisciplinary assessment" is the continual involvement of all skilled professional staff involved in a patient's plan of care from the initial assessment through discharge, which should include periodic discussions among the team regarding the patient's health status and recommendations for the plan of care. An interdisciplinary approach recognizes the contributions of various health care disciplines (MDs, RNs, LPN/LVN, PT, OT, SLP, MSW, HH aides) and their interactions with each other to meet the patient's needs.

CHAPTER 7:

50.7 - Part-Time or Intermittent Home Health Aide and Skilled Nursing Services

Where a patient is eligible for coverage of home health services, Medicare covers either part-time or intermittent home health aide services or skilled nursing services subject to the limits below. The law at §1861(m) of the Act clarified: "the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

40.2 - Skilled Therapy Services

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.

A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical

complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make an unskilled service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and

b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

Chapter 7:

30.2.1 - Content of the Plan of Care

The HHA must be acting upon a physician plan of care that meets the requirements of this section for HHA services to be covered.

The plan of care must contain all pertinent diagnoses, including:

• The patient's mental status;

• The types of services, supplies, and equipment required;

• The frequency of the visits to be made;

• Prognosis;

• Rehabilitation potential;

• Functional limitations;

• Activities permitted;

• Nutritional requirements;

• All medications and treatments;

• Safety measures to protect against injury;

• Instructions for timely discharge or referral; and

• Any additional items the HHA or physician chooses to include.

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

• The course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist;

• The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;

• The plan must include the expected duration of therapy services; and

• The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

30.2.2 - Specificity of Orders

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

EXAMPLE 1:

SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).

COP:

G520 §484.55(b)(1)

The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

Interpretive Guidelines §484.55(b)(1)

The start of care date is considered to be the first visit where the HHA actually provides hands on, direct care services or treatments to the patient. If an initial assessment is completed without any direct care services being provided by the HHA during the assessment visit, the date of that initial assessment visit would not be the start of care date. The comprehensive assessment must be completed within 5 calendar days of the first visit where the HHA provides hands on, direct care services/treatments to the patient.

G572

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

Interpretive Guidelines §484.60(a)(1)

"Patient-specific measurable outcome" is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization.

Patient-specific goals must be individualized to the patient based on the patient's medical diagnosis, physician's orders, comprehensive assessment and patient input. Progress/non-progress toward achieving the goals is evaluated through measurable outcomes. The HHA must include goals for the patient, as well as patient preferences and service schedules, as a part of the plan of care (See §484.60(a)(2) below).

"Periodically reviewed" means every 60 days or more frequently when indicated by changes in the patient's condition (see §484.60(c)(1)).

The patient's physician orders for treatments and services are the foundation of the plan of care. If the HHA misses a visit or a treatment or service as required by the plan of care, which results in any potential for clinical impact upon the patient, then the HHA must notify the responsible physician of such missed treatment or service. The physician decides whether the treatment or service may be skipped or whether additional intervention is required by the HHA due to the clinical impact on the patient.

If the patient or the patient's representative refuses care that could impact the patient's clinical wellbeing (such as dressing changes or essential medication) on more than one occasion, then the HHA must attempt to identify the reason for the refusal. If the HHA is unable to identify and address the reason for the refusal, then the HHA must communicate with the patient's responsible physician to discuss how to proceed with patient care.

The physician should not be approached to reduce the frequency of services based solely on the availability of HHA staff.

In instances where the HHA receives a general referral from a physician that requests HHA services but does not provide the actual plan of care components (i.e., treatments and observations) for the patient, the HHA will not be able to create a comprehensive plan of care to

include goals and services until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician.

G574

§484.60(a)(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;

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(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.

Interpretive Guidelines §484.60(a)(2)

(i) "All pertinent diagnoses" means all known diagnoses.

(ii) Mental status is generally screened by asking the patient questions on orientation to time, place and person.

(ii) Psychosocial status, as relevant to the patient's plan of care, may include but is not limited to, interpersonal relationships in the immediate family, financial status, homemaker/household needs, vocational rehabilitation needs, family social problems and transportation needs.

COP

G512

§484.55(a) Standard: Initial assessment visit.

G514

§484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

Interpretive Guidelines §484.55(a)(1)

For patients receiving only nursing services or both nursing and rehabilitation therapy services, a registered nurse must conduct the initial assessment visit. For patients receiving rehabilitation therapy services only, the initial assessment may be made by the applicable rehabilitation skilled professional rather than the registered nurse. See §484.55(a)(2).

The initial assessment bridges the gap between when the first patient encounter occurs and when a plan of care can be implemented. "Immediate care and support needs" are those items and services that will maintain the patient's health and safety through this interim period, i.e., until the HHA can complete the comprehensive assessment and implement the plan of care. "Immediate care and support needs" may include medication, mobility aids for safety, skilled nursing treatments, and items to address fall risks and nutritional needs.

The clinical record must demonstrate that homebound status/eligibility for the Medicare home health benefit was determined and documented during the initial visit.

An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient's return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or to accommodate the convenience of the agency.

In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record.

COP

G1022 §484.110(a)(6)

(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or

(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or

(iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

Interpretive Guidelines §484.110(a)(6)

Discharge summaries typically contain the following items:

• Admission and discharge dates;

• Physician responsible for the home health plan of care;

• Reason for admission to home health;

• Type of services provided and frequency of services;

• Laboratory data;

• Medications the patient is on at the time of discharge;

• Patient's discharge condition;

• Patient outcomes in meeting the goals in the plan of care; and

• Patient and family post-discharge instructions.

A discharge summary must be sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within five (5) business days of the date of the order for discharge from the responsible physician.

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70 The contents of a transfer summary typically contains the same components as a discharge summary.

Chapter 7

10.6 - Low Utilization Payment Adjustment (LUPA)

The LUPA threshold varies for a 30-day period of care depending on the payment group to which it is assigned. For each payment group, the 10th percentile value of visits is used to create a payment group-specific LUPA threshold with a minimum threshold of at least 2 visits for each group. A 30-day period with visits less than the LUPA threshold for the payment group is paid the national per visit amount by discipline adjusted by the appropriate wage index based on the site of service of the beneficiary. Such periods that do not meet the LUPA threshold for the payment group are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full 30-day period payment amount. The national per visit amounts by discipline (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) are updated and published annually by the applicable market basket for each visit type. To offset the full cost of longer, initial visits in some LUPA periods, the LUPA payment is increased by an add-on amount for LUPAs that occur as the only 30-day period or the initial 30-day period during a sequence of adjacent periods.

10.7 - Partial Payment Adjustment

10.7 - Partial Payment Adjustment

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Partial Payment Adjustment Criteria

An HHA receives a national, standardized 30-day payment of a predetermined rate for home health services unless CMS determines an intervening event warrants a new 30-day period for purposes of payment.

The partial payment adjustment is a proportion of the period payment and is based on the span of days including the start-of-care date (for example, the date of the first billable service) through and including the last billable service date under the original plan of care before the intervening event, defined as a—

● Beneficiary elected transfer, or

● Discharge and return to home health that would warrant, for purposes of payment, a new OASIS assessment, physician certification of eligibility, and a new plan of care.

When a new 30-day period begins due to an intervening event, the original 30-day period will be proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event. The proportional payment is the partial payment adjustment.