SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU
Home Health Policy Manual

Title: **Home Health Policy 404**
Section: **ELIGIBILITY FOR SERVICES**
Subject: **Plan of Care**
Reference: **ARM 37.40.702, 42 CFR 440.70, 42 CFR 484.18**
Supersedes: **Policy 404, Issued 11/01/2001**

PLAN OF CARE

Home Health services must be based on orders written by the physician and provided under a plan of care developed cooperatively by the Home Health agency staff and the beneficiary's attending physician.

UNDER THE CARE OF A PHYSICIAN

The member must be under the care of a physician who is qualified to sign the physician certification and plan of care. The physician may be a doctor of medicine, osteopathy, or podiatric medicine (a doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).

CONTENT OF THE PLAN OF CARE

The Home Health Agency (HHA) must be acting upon a physician plan of care that includes the following:

1. Member's mental status;
2. Diagnosis;
3. Types of services, supplies, and equipment required;
4. Frequency of visits to be made;
5. Prognosis;
6. Rehabilitation potential;
7. Functional limitations;
8. Activities permitted;
9. Nutritional requirements;
10. All medication and treatments;
11. Safety measures to protect against injury;
12. Instructions for timely discharge or referral; and

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

SPECIFICITY OF ORDERS

The orders on the plan of care must indicate the type of services to be provided to the member, 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.

All oral orders must be received, documented, and dated in the member's chart by agency personnel before the first visit. A verbal order must be followed by an actual signature within 30 days.

The provider agency is responsible for insuring Medicaid eligibility before service delivery.

REVIEW OF THE PLAN OF CARE

The total plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with the HHA professional personnel, at least every 60 days starting with the start of care date or more frequently when:

1. The beneficiary has elected a transfer;
2. A significant change in condition resulting in a change in the case-mix assignment;
3. A discharge and return to the same HHA during the 60 day episode; or
4. As often as the severity of the member's condition requires.

NOTE: Agency professional staff must promptly alert the physician to any changes that suggest a need to alter the plan of care.

Each review of the member's plan of care must contain the signature of the physician and the date of the review.

NOTE: A beneficiary's need for medical supplies, equipment and appliances must be reviewed by a physician annually.

CHANGES IN SERVICES AND DOCUMENTING ORAL ORDERS

All Home Health care services must be administered by agency staff only as directed by a physician and approved in the plan of care. All changes must be made in writing and signed by the physician or by a registered nurse on the staff of the agency receiving the physician's oral order. All changes in orders for drugs and narcotics must be signed by the physician.

TERMINATION OF THE PLAN OF CARE

If the beneficiary does not require Home Health services for the entire 60 day period, services should be discontinued. An exception is if the physician documents that the interval without such care is appropriate to the treatment of the member's illness or injury.