Title: Physician Orders and Plan of Care

Effective Date: 11/00; Rev. 6/02, 10/04, 11/06, 4/09

POLICY: The plan of care and physician orders will be developed, documented, signed, dated, and maintained as part of the clinical record in accordance with the following guidelines and each home health agency’s or facility’s policies. When necessary, the health home agency or facility (“Agency”) will assist the physician in determining the patient’s home health status. All information documented in the plan of care will accurately represent patient assessment information, orders received, and dates of action.

SCOPE: IHS system wide. All IHS and affiliate facilities providing Medicare certified home health services.

BACKGROUND: The purpose of this policy is to assure that the plan of care is appropriately developed, represents accurate data, and is signed and dated in accordance with applicable laws and regulations.

PROCEDURES:

1. Definition.

   1.1 The "plan of care" refers to the medical care and services established by the treating/supervising physician in collaboration with the home health nurse or therapist.

   1.2 A “physician”, for Medicare purposes, means a doctor of medicine, osteopathy, or podiatry who is legally authorized to practice medicine by a state in which he or she provides healthcare services.

   1.3 “Form 485” refers specifically to the form mandated by CMS (previously HCFA) for documentation of the plan of care at certification and recertification. It is required for all Medicare patients and by some other federal funded payors.


   2.1 An Agency must obtain a physician's written or verbal order for services before home health services may be initiated. This applies to services provided from the start of care date for the certification period until the
physician signs the plan of care certification. The verbal order must be documented in the medical record and the services included in a signed plan of care.

2.2 Services which are provided in subsequent certification periods (recertification) are considered to be provided under the subsequent plan of care when there is a verbal order to continue services into the recertification period. The verbal order must be obtained before the services are provided.

2.3 Services provided after the end of the initial certification period and before a verbal order or physician signed recertification plan of care is obtained are not considered provided under a plan of care. These services are not considered as having a physician’s order and are, therefore, not considered covered under Medicare and may not be billable under Medicaid (i.e., can only bill Medicaid if a verbal order is received for continuation of ongoing care).

2.4 Increases in the frequency of services or the addition of new services during a certification period must be authorized by the physician before they are provided.

2.5 The plan of care must be reviewed and signed by the physician who established or will be responsible for supervising the plan of care at least every 60 days.

2.5.1 Each review of a patient's plan of care must contain the signature of the physician and the date of review.

2.5.2 If the physician fails to date the review, the Agency may stamp “date received in the agency” with the receipt date.

2.6 When patient records are maintained by computer rather than hard copy, electronic signatures can be used. All electronic signatures must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. Safeguards must be in place to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown. This process must be submitted to and approved by the Intermediary.

2.7 A plan of care/order may be transmitted by facsimile machine. The Agency is not required to have the original signature on file. It is the responsibility of the Agency to obtain original signatures if an issue should arise that requires verification of an original signature.
2.8 Verbal orders received from a physician are valid at the time they are received. Verbal orders involving patient care cannot be generated/written/carried out without communication with the physician. Regulations allow a physician’s “agent” who may be the office nurse, liaison nurse, etc., to relay the order. Direct communication with the physician is not required.

2.9 Verbal orders are to be promptly transcribed to a physician order form/plan of care and sent to the physician for signature. An order may be entered late if documentation is present in the clinical record to support the late order. Backdating of orders is not allowed.

2.10 Verbal orders must be documented, signed and dated by the physician (or dated as received back in Agency) before Agency can bill Medicare. Orders affecting frequency must be signed prior to billing Medicaid.

3. Certification of Need/Appropriateness of Home Care Services.

3.1 The Form 485 contains the statement of home health certification (locator 26) required for Medicare beneficiaries. When the 485 is signed, the physician is certifying that:

3.1.1 Home health services are needed because the patient is homebound;

3.1.2 The patient needs intermittent skilled nursing services, physical therapy, speech language pathology services, or has a continuing need for occupational therapy;

3.1.3 A plan of care has been established and is periodically reviewed by the physician; and

3.1.4 The patient was under the care of the physician when the home health services were furnished.

4. Content of the Plan of Care/Orders.

4.1 The plan of care for all home health patients must contain the following:

4.1.1 All pertinent diagnoses.

4.1.2 The patient’s mental state.

4.1.3 The types of services to be provided, including discipline, frequency, and duration.
4.1.4 Supplies and equipment ordered.

4.1.5 Prognosis, rehabilitation potential, goals, functional limitations, activities permitted.

4.1.6 Nutritional requirements.

4.1.7 Medications.

4.1.8 Treatments.

4.1.9 Safety measures to protect against injury.

4.1.10 Discharge plans and any additional items which the Agency or physician wants to include.

4.2 The orders contained in the plan of care must include the type of services to be provided, the discipline which will provide the service, the frequency at which the service will be provided, and the duration of the service.

4.2.1 The frequency of visits may be stated as a specific range to allow the most appropriate level of care. When a range of visits is stated, the upper limit of the range is considered the physician's order. The upper limit of the range is also used when evaluating if the Medicare intermittent requirement is met.

4.2.2 PRN orders (Per Request, as Needed) are acceptable only when they are qualified to a specific potential need of the patient and quantified to a specific number of visits to meet this need. A PRN order may not set forth a range for the frequency of visits. When a PRN visit is made, the date and reason for the visit should be explained in the medical record. When an extra visit is needed and the plan of care contains open ended and/or unqualified PRN orders, a separate physician order must be obtained and documented.

5. **Physician / Staff Qualifications.**

5.1 A physician's verbal order to provide services may be accepted and put in writing by personnel authorized to do so by state and federal laws and regulations, as well as the Agency's internal policies.

5.2 The orders must also be co-signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech language pathologist, occupational therapist, or medical social worker)
responsible for furnishing or supervising the ordered services. The orders may be signed after the services have been provided as long as the Agency personnel who received the verbal orders notifies the nurse or therapist before the service is provided. This allows the services, based on the verbal order, to be provided without delay pending the signature.

/s/ William B. Leaver

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