SECTION 14 - SPECIAL DOCUMENTATION REQUIREMENTS

SECTION 14-SPECIAL DOCUMENTATION REQUIREMENTS

The purpose of this section is to aid the provider in being able to identify and correctly complete the documentation required for coverage of Medicaid home health services. Copies of the required documentation *must* be maintained in the patient's record.

14.1 PLAN OF CARE

Each submitted home health claim *must* be documented with a physician signed and dated plan of care. The HCFA-485 Home Health Certification and Plan of Treatment is designed to meet the regulatory requirements for both the physician's home health plan of care and home health certification and recertification requirements.

NOTE: When billing for home health services that have been prior authorized, the HCFA-485 and HCFA-486 should *not* be attached to a paper claim; and the Home Health segments of the institutional 837 transaction do *not* need to be populated.

Providers may use either the old or new (04/87) versions of the HCFA-485, HCFA-486 and HCFA-487 forms for Medicaid recipients. The Missouri Medicaid Program accepts either originals or copies.

If a home health agency is billing electronically, various segments in Loops 2300, 2305, and 2310A of the institutional 837 transaction provide elements in which home health agencies submit the information that is documented on a HCFA-485, HCFA-486 and HCFA-487. The specific segments that *must* be completed are NTE, CR6, CRC, CR7, HSD, and NM1. The Companion Guide provides additional information for populating home health segments and can be viewed on Missouri Medicaid's web page at http://manuals.momed.com/. To access the Companion Guides, select Missouri Medicaid Electronic Billing Layout Manuals; select System Manuals; select EDI Companion Guides, select X12N Version 4010A1 Companion Guide.

14.2 HCFA-485—HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT (FOR DOCUMENTATION PURPOSES

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1 Patient's HI Claim No. (Patient’s 8-digit Medicaid ID Number)	Enter the patient's eight digit Medicaid or MC+ Identification Number as shown on the patient's ID card or temporary eligibility notice.
2 SOC Date	Enter the day on which covered home health

		services began in six digit month, day, year format (MMDDYY), (e.g., 061504).
3	Certification Period	Enter the six digit month, day, year (MMDDYY), (e.g., 061504-081504), which identifies the period covered by the physician's plan of care. The "From" date for the initial certification *must* match the start of care date. The "To" date can be *up to*, but never exceed, two calendar months and mathematically never exceed 62 days. Always repeat the "To" date on a subsequent recertification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period. EXAMPLE: Initial certification "From" date 061504. Initial certification "To" date 081504. Recertification "From" date 081504. Recertification "To" date 101504.
4	Medical Record No.	Enter the patient's medical record number that the provider assigns. This is an *optional* item. If *not* applicable, enter "N/A"
5	Provider No.	Enter the 9-digit number issued by Medicaid (e.g., 581234567).
6	Patient's Name and Address	Enter the patient's last name, first name and middle initial as shown on the ID card followed by the street address, city, state and ZIP code.
7	Provider's Name and Address	Enter the provider's name and/or branch office (if applicable), street address (or other legal address), city, state, and ZIP code.
8	Date of Birth	Enter the date (6-digit month, day, year) in numerics (MMDDYY, e.g. 040120).
9	Sex	Check the appropriate box.
10	Medications: Dose/	Enter all physician's orders for all

	Frequency/Route	medications, including the dosage, frequency and route of administration for each. • Use the addendum HCFA-487 for drugs which *cannot* be listed on the Plan of Care. • Use the letter "N" after the medication(s) which are "new" orders. • Use the letter "C" after the medication(s) which are "change" orders either in dose, frequency or route of administration.
11	Principal Diagnosis, ICD-9-CM, Date	Enter the principal diagnosis on all HCFA-485. forms. The principal diagnosis is the diagnosis most related to the current plan of treatment. It may or may not be related to the patient's most recent hospital stay, but *must* relate to the services rendered. If more than one diagnosis is treated concurrently, enter the diagnosis that represents the most acute condition and requires the most intensive services. Enter the appropriate ICD-9-CM code for the diagnosis in the space provided. The code *must* be the full ICD-9-CM diagnosis code including all digits. V codes are acceptable as both primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, do *not* use the V code when the acute diagnosis code is more specific to the exact nature of the patient's condition. EXAMPLE: Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). Use V55.3 as the primary diagnosis since it is more specific to

the nature of the proposed services.

The following is a list of acceptable V codes:

V24.2—Routine Postpartum Follow-Up Care

V46.0—Dependence on Aspirator

V46.1—Dependence on Respirator

V53.5—Fitting and Adjustment of Other Intestinal Appliance

V53.6—Fitting and Adjustment of Urinary Devices

V55.0—Attention to Tracheostomy

V55.1—Attention to Gastrostomy

V55.2—Attention to Ileostomy

V55.3—Attention to Colostomy

V55.4—Attention to Other Artificial Opening of
Urinary Tract

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan of care.

List the actual medical diagnostic term next to the ICD-9-CM code. Do *not* describe in narrative format any symptoms or explanations. Do *not* use surgical procedure codes.

The date is always represented by six digits (MMDDYY); if the exact day is *not* known, use 00 in the middle section. The date of onset is specific to the medical reason for home health care services. If a condition is chronic or long term in nature, use the date

		of exacerbation. Use one or the other, *not* both. Always use the latest date. Enter all dates as close as possible to the actual date.
12	Surgical Procedure, ICD-9-CM, Date	Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in item 8 is "Fractured Left Hip", note the ICD-9-CM code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 060904). If a surgical procedure was *not* performed or is *not* relevant to the plan of care, do *not* leave the box blank. Enter N/A. Use the addendum (HCFA-487) for additional relevant surgical procedures. At a minimum, the month and year *must* be present for the date of surgery. Use 00 if the day is unknown.
13	Other Pertinent Diagnoses ICD-9-CM, Date	Enter all pertinent diagnoses, both narrative and ICD-9-CM codes, relevant to the care rendered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of care was established or subsequently developed. Exclude diagnoses that relate to an earlier episode which have no bearing on this plan of care. These diagnoses can be changed to reflect changes in the patient's condition. In listing the diagnoses, place them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided. If there are more than four pertinent diagnoses, use the addendum (HCFA-487) to list them. Enter N/A if there are no pertinent secondary diagnoses. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. Note the date of onset or exacerbation for each as close to the actual date as possible. If

		the date is unknown, note the year and place 00 in the month or day *not* known. NOTE: When billing for postnatal assessment and follow-up care on a paper claim, the date and time of delivery should be included in this field.
14	DME and Supplies	Enter all non-routine supplies which are being billed to Medicaid. For example, dressing changes may require use of 4x4's, telfa pads, kling and non-allergic tape. Catheter changes may require catheter kit and irrigation kit as well as irrigating solutions. Exact amount of usage need *not* be listed. Enter N/A if no supplies are billed. Medicaid home health does *not* provide coverage of DME items. Do *not* enter item(s) of DME ordered by the physician that are billed to the Medicaid Durable Medical Equipment Program.
15	Safety Measures	Enter the physician's instructions for safety measures.
16	Nutritional Req.	Enter the physician's order for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Record fluid needs or restrictions. Total Parental Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications. If more space is necessary, use the HCFA-487.
17	Allergies	Enter medications to which the patient is allergic and other allergies the patient experiences (e.g., foods, adhesive tape, iodine). "No known allergies" may be an appropriate response.
18A	Functional Limitations	Check all items which describe the patient's current limitations as assessed by the physician and agency.

18B	Activities Permitted	Check the activity(ies) which the physician allows and/or for which physician orders are present. If "Other" is checked under either the "Functional Limitations" or "Activities Permitted" category, provide a narrative explanation in Item 17 of the HCFA-486.
19	Mental Status	Check the block(s) most appropriate to describe the patient's mental status. If "Other" is checked, specify the conditions.
20	Prognosis	Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good.
21	Orders for Discipline and Treatments(Specify Amount/Frequency/ Duration)	Specify the frequency and expected duration of the visits for each discipline ordered. State the duties/ treatments to be performed by each. A discipline may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social services (MSS), home health (AIDE), or others (e.g., nutritionist, male orderly, respiratory therapist). Orders *must* include all disciplines and treatments, even if they are *not* billable to Medicaid.
22	Goals/Rehabilitation Potential/Discharge Plans	Enter information which reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge. Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information is pertinent to the nature of the patient's condition and ability to respond. The words "Fair" or "Poor" alone, are *not* acceptable. Add descriptors. EXAMPLE: Rehabilitation potential good

for partial return to previous level of care, but patient will probably *not* be able to perform ADL independently.

Where daily care has been ordered, be specific as to the goals and when the need for daily care is expected to end.

EXAMPLE: Granulation of wound with daily wound care is expected to be achieved in four weeks. Skilled nursing visits are decreased to 3x/week at that time.

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

23 Verbal Start of Care Nurse's Signature and Date

This verifies that a nurse spoke to the attending physician and has received verbal authorization to visit the patient. This date *may* precede the SOC date in Item 2, and may precede the "From" date in Item 3.

The item is signed by the nurse receiving the verbal orders, by the nurse responsible for the completion of the form or by the nonclerical agency representative responsible for review. The date is necessary. If the nurse who received the orders does *not* prepare the HCFA-485, then the orders *must* be transcribed to a form, signed and dated by the nurse and retained in the agency files. Document the initial and ongoing communications with the physician.

This item is applicable only to certification. Enter N/A if recertification, or if *not* applicable to the certification period.

24 Physician's Name and Address

Print the physician's name and address. The attending physician is the physician who establishes the plan of care and who certifies and recertifies the medical necessity of the visits and/or services. Mention supplemental

	physicians involved in a patient's care only on the HCFA-486.
25 Date HHA Received Signed POC	Enter the date the provider received the signed POC from the attending/referring physician. Enter N/A if Item 27 DATE is completed.
26 Physician Certification	Check whether this is an initial certification or a recertification.
27 Attending Physician's Signature and Date Signed	The attending physician signs and dates the plan of care/certification prior to submitting the claim. Rubber signature stamps are *not* acceptable. The form may be signed by another physician who is authorized by the attending physician to care for the patient in the attending physician's absence. Do *not* predate the orders for the physician, nor write the date in this field. If the physician left it blank, enter the date the provider received the signed POC under Item 25. Do *not* enter N/A. Submit a *signed* copy of the HCFA-485. Retain a copy for record keeping purposes.

14.3 HCFA-486—MEDICAL UPDATE AND PATIENT INFORMATION (FOR DOCUMENTATION PURPOSES)

The fields required on the HCFA-486 (04/87) version for Medicaid are as follows:

- Fields #1, 3, 5 (Medicaid Provider Number);
- Fields #6, 7, 8, 9, 10, 12, 14, 15, 16;

  NOTE: If the physician orders a change in frequency of services or a new discipline, enter a notation in Field #16 and attach a copy of the physician's signed order. Any other order change should be listed in the update of the HCFA-486 form.
- Fields #17, 19 and 22.

FIELD NUMBER & NAME		INSTRUCTIONS FOR COMPLETION
1	Patient's HI Claim No. (Patient's 8 digit Medicaid ID Number)	See HCFA-485 instructions, Field #1.
2	SOC Date	Leave Blank
3	Certification Period	See HCFA-485 instructions, Field #3.
4	Medical Record No.	Leave Blank
5	Provider No.	See HCFA-485 instructions, Field #5.
6	Patient's Name	See HCFA-485 instructions, Field #6.
7	Provider's Name	See HCFA-485 instructions, Field #7.
8	Medicare Covered	State the agency's opinion as to whether the patient's care is Medicare covered or noncovered. Check the appropriate box.
9	Date Physician Last Saw Patient	Enter the date the physician last saw the patient if this information can be obtained during the home visit. If unable to determine this date, enter "Unknown".
10	Date Last Contacted Physician	Note the date MMDDYY (e.g., 071504) of the most recent physician contact (verbal or written) regarding the status or problems encountered.
11	Is Patient Receiving Care in an 1861 (J)(1) SNF or Equivalent?	Leave Blank
12	Certification/Recertification/ Modification	Check one of the blocks to identify this plan of care as a certification, recertification or modification. Modification refers to the HCFA-486 form submitted with an interim claim to report changes in the disciplines or number of visits ordered.
13	Specific Services and Treatments	Leave Blank

14 Dates of Last Inpatient Stay	Enter the admission and dates (month, day and year: e.g., 060204-061004) of the last inpatient stay relevant to the care provided. Enter N/A if *not* applicable. NOTE: When billing for postnatal assessment and follow-up care on a paper claim, the date and time of discharge should be included in this field.
15 Type of Facility	Identify the type of facility (e.g., acute, NF, rehabilitation). Enter N/A if *not* applicable.
16 Updated Information	Record any new orders, treatments or changes and associated date(s) from the time the HCFA-485 is completed to the time the HCFA-486 is completed. On certifications, enter the clinical findings of the initial assessment visit for all disciplines involved in the care plan. Describe the clinical facts about the patient that require skilled home health services. Include specific dates. On recertifications, record significant clinical findings for each discipline incorporating all symptoms and changes in the patient's condition during the last 60 days of service. Include specific dates. Document progress or nonprogress for each discipline. Include any pertinent information on a patient's inpatient stay and the purpose of any agency contact with the physician, if applicable.
17 Functional Limitations	Provide a narrative description of the patient's prior functional status and current limitations and activities permitted. Elaborate on the information in the checklist (HCFA-485 Field #18A and #18B) and provide any other information needed to

		describe the patient. Clearly reflect the restrictions imposed by the physician. Include a description of ADL limitations and indicate the type of scope of assistance needed. Include a brief statement of why the patient is homebound. Include a description of the home environment, if it is relevant to the homebound determination, e.g., patient lives in a third floor walk-up apartment and is recovering from congestive heart failure.
19	Unusual Home/Social Environment	Use this block to include information which would enhance the reviewer's concept of the home situation and help justify the need for services in the home, e.g. patient lives with retarded son who is unable to provide any assistance or to comprehend instructions.
22	Nurse or Therapist Completing or Reviewing Form/Date (MO,DAY,YR)	The nurse or therapist responsible for the completion of the form or a nonclerical agency representative or supervisor responsible for the review signs and dates the form.

14.4 HCFA-487— ADDENDUM TO THE PLAN OF TREATMENT/ MEDICAL UPDATE (FOR DOCUMENTATION PURPOSES OR TO BE ATTACHED TO A PAPER CLAIM)

The HCFA-487 is used only as an addendum to the HCFA-485/HCFA-486 when additional space is needed to complete the fields on these forms. The data for each field *must* be initiated on the HCFA-485 or HCFA-486. Use a separate addendum for the plan of treatment and the medical update. If the addendum is used to continue items on the plan of treatment, forward the HCFA-487 to the physician with the HCFA-485 for the physician's signature.

To provide additional documentation of items on the plan of treatment or medical information, check the appropriate block. Identify the item being addressed under Item 8. For example, if the plan of treatment block is checked and Item 11 (medications) requires additional space, specify Item 11 on the left margin of column 8. Upon completion of Item 11, note the next item number, e.g., Item 14 (Supplies) then complete that item.

Instruction for completion of the required fields follows. Please reference the sample HCFA-487 included in this Section.

FIELD NUMBER & NAME	INSTRUCTIONS FOR COMPLETION
1 Patient's HI Claim No. (Patient's 8-digit Medicaid ID Number)	See HCFA-485 instructions, Field #1.
2 Start of Care Date	See HCFA-485 instructions, Field #2.
3 Certification Period	See HCFA-485 instructions, Field #3.
4 Medical Record Number	See HCFA-485 instructions, Field #4.
5 Provider Number	See HCFA-485 instructions, Field #5.
6 Patient's Name	See HCFA-485 instructions, Field #6.
7 Provider Name	See HCFA-485 instructions, Field #7.
8 Item Number	Indicate the item number for which additional information is being provided.
9 Signature of Physician	If the certification/plan of treatment block is checked, the physician's signature or an annotation is required on the HCFA-485 which indicates that the physician is aware that he/she is signing for information contained on additional pages (e.g., page 1 of 2). Retain a copy for filing purposes. The physician enters the date the addendum was signed in this space.
10 Date	If the medical update/patient information block is checked, the Nurse/Therapist filling out the form signs.
11 Optional Name/Signature of Nurse/Therapist	The name/signature of the nurse/therapist appears in this field.
12 Date	The date the nurse/therapist filled out the addendum appears in this space.

14.5 INTERIM ORDER

Any changes to the plan of treatment *must* be documented on an interim order. If filing an electronic claim, the appropriate information *must* be provided in the home health segments of the institutional 837 transaction.

An interim order is required when:

- there has been an increase or decrease in frequency and/or duration of visits and/or addition of a new discipline since the certification/recertification; or
- there is an extension of daily visits beyond the initial 2-3 week period certified by the physician.

In the case of medication changes *only*, e.g. increase Amoxicillin from 250 mg. to 300 mg., 3 x per day, it is *not* necessary to send the interim order when billing. Medication changes should be listed on the HCFA-486 update.

Medicaid does *not* require a standard interim order form. However, in addition to the ordered changes, the interim order *must* contain the following items:

- The patient's name;
- The date the change was ordered; and
- The physician's signature and date.

14.6 PRIOR CONTENTS NO LONGER APPLICABLE

14.7 WEIGHT-FOR-HEIGHT GRAPH

Because eligibility for low birthweight or failure-to-thrive (FTT) benefits depend upon the child's weight for height deficit, a growth chart *must* be maintained in the patient's record. A copy of the growth chart *must* be submitted with paper claims; if billing electronically, the necessary information should be provided in the home health segments of the institutional 837 transactions.

It is recommended that providers use the chart developed by the National Center for Health Statistics. Reference the Weight-for-Height Graph, Boys from Birth to 36 Months or Weight-for-Height Graph, Girls from Birth to 36 Months charts. Additional copies may be obtained from the Missouri Department of Health and Senior Services or providers may make copies of the sample form. Both the weight and height, with dates of observation, *must* be clearly recorded on the growth chart.

END OF SECTION

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