

PLAN OF CARE, CERTIFICATIONS AND RECERTIFICATIONS FOR MEDICARE PATIENTS

ETHICS & COMPLIANCE DEPARTMENT

SCOPE:

Applies to all Evolution Health colleagues. For purposes of this policy, all references to “colleague” or “colleagues” include temporary, part-time and full-time employees, independent contractors, clinicians, officers and directors.

PURPOSE:

The purpose of this Policy is to set forth the general guidelines established by Evolution Health (the “Company”) for the establishment of the physician plan of care, and for Medicare patients, the initial certification and subsequent recertification that the patient is eligible for the Medicare home health benefit.

POLICY:

It is Company policy that a plan of care and physician orders will be established for each patient in accordance with this policy. Moreover, for Medicare patients, the Company will obtain certifications and subsequent recertification of eligibility for the Medicare home health benefit in accordance with applicable laws and this policy.

PROCEDURE:

- I. **The Content of the Plan of Care.** For services to be covered, the individualized plan of care must specify the services necessary to meet the patient specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits that establish the need for such services. All care provided must be in accordance with the plan of care.
- A. The plan of care for all home health patients must contain all pertinent diagnoses, including:
 - The patient’s mental state;
 - The types of services to be provided, including discipline, frequency, and duration;
 - Supplies and equipment ordered;
 - Prognosis, rehabilitation potential, goals, functional limitations and activities permitted;

- Nutritional requirements;
 - Medications;
 - Treatments;
 - Safety measures to protect against injury; and
 - Discharge plans and any additional items the physician wants to include.
- B. 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.
- C. The orders contained in the plan of care must include the type of services to be provided, the discipline that will provide the services, the frequency at which the services will be provided, and the duration of the services. For therapy services, the specified modality must be included.
- 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.
 - PRN orders 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.
- D. Changes in the patient's condition that require a change in the plan of care should be documented in the patient's clinical record. The physician should be promptly notified of any changes that suggest a need to alter the plan of care.
- III. Physician Certification. For every Medicare patient, a physician must certify that:
- A. The home health services are necessary because the individual is confined to his or her home and needs intermittent skilled nursing care, physical therapy and/or

speech language pathology services, or has a continuing need for occupational therapy;

- B. A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and
- C. The services are or were furnished while the patient was under the care of a physician.

IV. Signatures. The attending physician must sign and date the Plan of Care/certification.

- A. Rubber signature stamps are not acceptable.
- B. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence.
- C. Facsimile signatures are permitted.
- D. Where a Company location maintains patient records electronically rather than by hard copy, electronic signatures are acceptable. All electronic signatures must be appropriately authenticated and dated.

V. Face-to-Face Encounter Requirements.

- A. The certifying physician must document that he or she, or an allowed non-physician practitioner (“NPP”), had a face-to-face encounter with the patient. The certifying physician must certify that the face-to-face encounter occurred within the required timeframe, as described in Section V.D. below, and that the encounter was related to the primary reason for home health services. The certifying physician must document the date of the face-to-face encounter as part of the certification.
- B. The face-to-face encounter may be performed by one of the following:
 - 1. The certifying physician;
 - 2. A physician, with privileges, who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health;
 - 3. A nurse practitioner or clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or the acute/post-acute physician with privileges who cared for the patient in the acute/post-acute care facility from which the patient was directly admitted to home health;
 - 4. A certified nurse-midwife as authorized by State law under the supervision of the certifying physician or under the supervision of the acute/post-acute physician with privileges who cared for the patient in the acute/post-acute care facility from which the patient was directly admitted to home health; or

5. A physician assistant under the supervision of the certifying physician or the acute/post-acute physician with privileges who cared for the patient in the acute/post-acute care facility from which the patient was directly admitted to home health.
- C. The certifying physician must document the face-to-face encounter either on the signed and dated physician certification or on a signed addendum to the physician certification. The medical records of the certifying physician, or the acute/post-acute care facility from which the patient was directly admitted to home health, must contain sufficient documentation to support the physician's certification of the patient's eligibility for home health services.
1. The Company shall obtain the documentation supporting the patient's eligibility for home health services from the certifying physician or the acute/post-acute care facility.
 2. The Company may provide information to the certifying physician about the patient's home bound status and need for skilled care for the certifying physician to incorporate into his or her medical record for the patient. Such information shall corroborate the certifying physician's and/or the acute/post-acute care facility's documentation/medical record entries.
- D. The face-to-face encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care date. When a physician orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the certifying physician or an allowed NPP must see the patient again within 30 days after admission.
- E. An encounter between the home health patient and the attending physician who cared for the patient during an acute/post-acute stay (such as a hospitalist) can satisfy the face-to-face encounter requirement. This physician may certify the need for home health care based on his/her contact with the patient and establish and sign the plan of care.
- F. The face-to-face encounter may be performed via telehealth service in an approved originating site (e.g., the office of a physician, a hospital, a Rural Health Clinic, or a skilled nursing facility).
- VI. Review of the Plan of Care/Recertification. 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.

For Medicare patients, the physician must also *recertify* at intervals of at least once every sixty (60) days that there is a continuing need for services.



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POLICY REVIEW

The Ethics & Compliance Department will review and update this Policy and all HIPAA policies when necessary in the normal course of its review of the Ethics & Compliance Program.