GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

DHCF Transmittal No. 11-15

Officer of the Director

TO: **Home Health Agencies Enrolled in the District of Columbia Medicaid Program**

FROM: **Linda Elam, PhD, MPH**
Deputy Director, Medicaid

DATE: **June 15, 2011**

SUBJECT: **Effective July 1, 2011: New Plan of Care Form for Medicaid Personal Care Aide and Home Health Services**

Effective July 1, 2011, the Department of Health Care Finance (DHCF) is requiring a new Plan of Care Form for Personal Care Aide and home health services. As before, this form must be completed, signed and dated by the home health agency provider registered nurse (RN). Also as before, within thirty (30) days of start of care, the form must be signed by the patient's physician or nurse practitioner.

Background

As you know, Title 29 of DC Municipal Regulations (DCMR) for the Medicaid program requires that:

> *"Each provider shall develop a written plan of care within seventy-two (72) hours of the initial evaluation of the patient based upon an assessment of the patient's level of functional limitations"* (Section 5006.2); and
>
> *The plan of care shall be approved by the patient's physician or advanced practice registered nurse and re-certified no less than six (6) months after the initial certification and each re-certification thereafter."* (Section 5006.4)

Until now, the DC Medicaid program has required Home Health Agency (HHA) providers to use the Centers for Medicare and Medicaid Services' (CMS') "Home Health Certification and Plan of Care" Form (also known as the HCFA 485 Form) as the plan of care form to fulfill this requirement.

However, as CMS no longer mandates the use of this form for Medicaid, and because we have received complaints about is functionality, we have revised this form to be more in accord with the specific requirements of our regulations and to highlight certain aspects of care. Please make photocopies of it *(attached)* and use it as the new plan of care for your patients when needed.

DHCF has developed this new standardized Plan of care (POC) form for all Medicaid Home Health Agency providers to utilize for PCA services and home health services. It was developed from the Extended Care Request form that has been used by home health agencies. Therefore, the content of the form should be familiar to you and easy to complete. However, we welcome your suggestions for its improvement. (We also have reduced the Extended Care Request Form to a simple one page request form, which will be sent to you in a separate transmittal).

This action is one step in a process that DHCF is taking to safeguard the integrity of and preserve PCA and home health benefits in a time of financial challenge. We welcome your ideas for further protecting the integrity of our personal care aide benefit and would also be happy to make presentations to groups of providers to explain other aspects of the Medicaid PCA and home health benefit.

Thank you in advance for your cooperation. Please contact Ericka Bryson-Walker, Project Manager at 202-442-9054 or ericka.walker@dc.gov if you have any questions.

Attachment:
New Plan of Care Form for Medicaid Personal Care Aide and Home Health Skilled Services

Government of the District of Columbia
Department of Health Care Finance
Division of Long-Term Care

Plan of Care for Medicaid Personal Care Aide (PCA), Home Health Aide and/or Skilled Nursing Services

To be completed by the Licensed Home Health Agency (DC Medicaid Provider). Please print clearly and complete all sections. If you have questions about this form, please call DHCF at (202) 724-4282.

Plan of Care Certification Period: From: _____ To: _____

This Plan of Care is for (check): [ ] Home Health Visits [ ] Home Health Hours [ ] Personal Care Aide Hours

(1) Name of Beneficiary: _____
First Name Middle Initial Last Name

(2) Permanent Address: _____

(3) Phone (_____) _____ – _____ (4) Date of Birth _____ / _____ / _____ (5) Sex _____

(6) SS# _____-_____-_____ (7) Medicare # _____ (8) Medicaid # _____

(9) Contact information for Next of Kin/Responsible Party (Indicate N/A, if applicable):

_____
First Name Middle Initial Last Name

(10) Permanent Address _____

(11) Phone (_____) _____ – _____

(12) Describe the home environment and the patient's support system (family and community resources):

_____

_____

_____

_____

_____

_____

(13) Diagnosis(es) causing patient's disability(ies) and other pertinent diagnoses or surgical procedures:

_____

_____

_____

_____

Name of Medicaid Beneficiary:_____

Medicaid ID:_____

(14) FUNCTIONAL LIMITATIONS:

[ ] Bathing
[ ] Toileting
[ ] Dressing
[ ] Eating
[ ] Getting in and out of bed
[ ] Taking medication prescribed for self-administration
[ ] Other (specify) _____

ACTIVITIES PERMITTED:

[ ] Bedrest
[ ] Complete bedrest
[ ] BRP
[ ] Up as tolerated
[ ] Transfer bed/chair
[ ] Toilet independently
[ ] Transfer bed/chair
[ ] Toilet with assistance
[ ] Other (specify) _____

[ ] Crutches
[ ] Cane
[ ] Wheelchair
[ ] Walker
[ ] No restriction

(15) Allergies: ❑ Yes, please explain ❑ No

_____

(16) Medication(s) (dose, route, and frequency):

_____

_____

_____

_____

(17) Skilled Nursing Service(s) Ordered (Specify amount/frequency/duration. If none, state none):

_____

_____

_____

_____

(18) Personal Care Aide/Home Health Aide Services Ordered (Specify amount/frequency/duration. If none, state none):

_____

_____

_____

_____

(19) Does the patient have a 24-hour management plan? (i.e., a plan for care when home health services/personal care aide services are not in the home)

❑Yes, please explain ❑No, RN documents recommendations

_____

_____

_____

Name of Medicaid Beneficiary:_____

Medicaid ID:_____

(20) Nutritional Requirements:

❑Yes, a specific diet is required. Explain below ❑No. Indicate 'None' below

_____

_____

_____

_____

(21) Date service(s) to begin: _____

Contact information for the RN completing form:

(22) Name of RN:_____
First Name Middle Initial Last Name

(23) Address _____

(24) Phone (_____) _____ – _____ (25) Fax (_____) _____ - _____

(26) Signature of RN completing form: _____ (27) Date: _____ / _____ / _____

Practitioner approving Plan of Care:

(28) Name of Physician/Nurse Practitioner: _____
First Name Middle Initial Last Name

(29) Address _____

(30) Phone (_____) _____ – _____ (31) Fax (_____) _____ - _____

(32) Physician/Nurse Practitioner Signature: _____ (33) Date: _____ /_____ /_____

The practitioner must sign the form within thirty (30) days of its prescription