Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM	Principal Diagnosis	Date
12. ICD-9-CM	Surgical Procedure	Date
13. ICD-9-CM	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date HHA Received Signed POT

24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Privacy Act Statement

Sections 1812, 1814, 1815, 1816, 1861, and 1862 of the Social Security Act authorize collection of this information. The primary use of this information is to process and pay Medicare benefits to or on behalf of eligible individuals. Disclosure of this information may be made to : Peer Review Organizations and Quality Review Organizations in connection with their review of claims, or in connection with studies or other review activities, conducted pursuant to Part B of Title XI of the Social Security Act; State Licensing Boards for review of unethical practices or nonprofessional conduct; A congressional office from the record of an individual in response to an inquiry from the congressional office at the request of that individual.

Where the individual's identification number is his/her Social Security Number (SSN), collection of this information is authorized by Executive Order 9397. Furnishing the information on this form, including the SSN, is voluntary, but failure to do so may result in disapproval of the request for payment of Medicare benefits.

Paper Work Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0357. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Mailstop N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

MEDICAID INSTRUCTIONS

FORM CMS-485 (formerly HCFA-485) "HOME HEALTH CERTIFICATION AND PLAN OF CARE"

Form CMS–485 (C-3) (02-94), (Formerly HCFA-485), "HOME HEALTH CERTIFICATION AND PLAN OF CARE" is a required attachment to the Medicaid Prior Authorization Form 1144. ("INSTRUCTIONS: PRIOR AUTHORIZATION FORM 1144", II. General Instructions, C.1., "Home Health Services".)

If provider has submitted a Form CMS-485 to Medicare for Home Health services, including Home Health Rehabilitative services, the MQD will accept a copy of the form in its entirety. If, however, the recipient is Medicaid only, please note the following:

- #1, #4, #5, #8, #9 have been omitted
- #6, #7, #24 require names only; addresses and telephone numbers have been omitted.

Please complete the following fields of the Form CMS-485 for Home Health services:

1. **Omit**
2. Start of Care Date
3. Certification Period
4. **Omit**
5. **Omit**
6. Patient's Name **(omit address)**
7. Provider's Name **(omit address and telephone number)**
8. **Omit**
9. **Omit**
10. Medications
11. ICD-9-CM, Principal Diagnosis, Surgical Procedure, Date
12. ICD-9-CM., Surgical Procedure, Date
13. ICD-9-CM, Other Pertinent Diagnoses, Date
14. DME and Supplies
15. Safety Measures
16. Nutritional Req.
17. Allergies

18.A. Functional Limitations
18.B. Activities Permitted

19. Mental Status
20. Prognosis
21. Orders for Discipline and Treatments
22. Goals/Rehabilitation Potential/Discharge Plans
23. Nurse's Signature and Date of Verbal SOC Where Applicable
24. Physician's Name **(omit address)**
25. Date HHA Received Signed POT
26. Attestation statement
27. Attending Physician's Signature and Date Signed
28. Attestation statement

** Detailed instructions are adapted from the attached **"Home Health Agency Manual, Chapter 11", Section 234.7, *Completion of Form CMS-485 (formerly HCFA-485), Home Health Certification and Plan of Care.***

Form CMS-485, "Home Health Certification and Plan of Care"

Completion of Form CMS-485, Home Health Certification and Plan of Care.--Form CMS-485 meets the regulatory requirements (State and Federal) for both the physician's home health plan of care and home health certification and recertification requirements.

Complete the following:

1. Patient's HICN.—**Omit**

2. Start of Care Date.--Enter the 6 digit month, day, year on which covered home health services began, i.e., MMDDYY (e.g., 101593). The start of care (SOC) date is the first Medicare billable visit if individual is dually eligible for Medicare/Medicaid. If individual is eligible for Medicaid only, SOC is the first Medicaid billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health care may be suspended and later resumed under the same start of care date in accordance with your internal procedures.

3. Certification Period.--Enter the 2 digit month, day, year, MMDDYY (e.g., 101593- 121593), 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 101593
   Initial certification "To" date 121593
   Recertification "From" date 121593
   Recertification "To" date 021594

4. Medical Record Number.—**Omit**

5. Provider Number.-- **Omit**

6. Patient's Name --Enter the patient's last name, first name, and middle initial as shown on the health insurance card. **Omit address**

7. Provider's Name--Enter your name and/or branch office (if applicable). **Omit address and telephone number.**

8. Date of Birth.— **Omit**

9. Sex.--**Omit**.

10. Medications: Dose/Frequency/Route.--Enter all physicians orders for all medications, including the dosage, frequency, and route of administration for each.
    - Use an Addendum for drugs which cannot be listed on the plan of treatment.
    - 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.

    "New" orders refer to medications which the patient has not taken recently, i.e., within the last 30 days. "Change" orders for medications include dosage, frequency, or route of administration changes within the last 60 days.

11. Principal Diagnosis, ICD-9-CM Code and Date of Onset/Exacerbation.-Enter the principal diagnosis on all CMS-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 you 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 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.

    EXAMPLES:
    Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). Use 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture.

    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 (V 55.3). Use V 55.3 as the primary diagnosis since it is more specific to the nature of the services.

    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. 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, to the best of your knowledge.

12. Surgical Procedure, Date, ICD-9-CM Code.--Enter the surgical procedure relevant to the care rendered. For example, if the diagnosis in Item 11 is "Fractured Left Hip", note the ICD-9-CM Code, the surgical procedure, and date (e.g., 81.62, Insertion of Austin Moore Prosthesis, 100293). 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 an addendum 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: Dates of Onset/Exacerbation, ICD-9-CM Code.--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 which developed subsequently. 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 an addendum 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 as close to the actual date as possible. If the date is unknown, note the year and place 00s in the month or day if not known.

14. DME and Supplies.--All nonroutine supplies must be specifically ordered by the physician or the physician's order for services must require the use of the specific supplies. Enter in this item, nonroutine supplies that you are billing to Medicare that are not specifically required by the order for services. For example, an order for foley insertion requires specific supplies, i.e., foley catheter tray. Therefore, these supplies are not required to be listed. Conversely, an order for wound care may require the use of nonroutine supplies which would vary by patient. Therefore, list the nonroutine supplies.

    If you use a commonly used commercially packaged kit, you are not required to list the individual components. However, if there is a question of cost or content, the intermediary can request a breakdown of kit components.

    List DME ordered by the physician that will be billed to Medicare and Medicaid. Enter N/A if no supplies or DME are billed.

15. Safety Measures.--Enter the physician's instructions for safety measures.

16. Nutritional Requirements.--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 Parenteral Nutrition (TPN) can be listed, and if more room is needed, place additional information under medications.

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 you.

18B. Activities Permitted.--Check the activity(ies) which the physician allows and/or for which physician orders are present.

19. Mental Status.--Check the block(s) most appropriate to describe the patient's mental status. If you check "Other", specify the conditions.

20. Prognosis.--Check the box which specifies the most appropriate prognosis for the patient: poor, guarded, fair, good, or excellent.

21. Orders for Discipline and Treatments (Specify amt/freq/dura).--The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline must be stated. A discipline may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), or home health aid (AIDE).

EXAMPLE OF PHYSICIAN'S ORDERS: Certification period is from 101593 to 121593.

OT - Eval., ADL training, fine motor coordination 3x/wk x 6 wks
ST - Eval., speech articulation disorder treatment 3x/wk x 4 wks
SN - Skilled observation and assessment of C/P and neuro status
instruct meds and diet/hydration, instruct 3x/wk x 2 wks
AIDE - Assist with personal care, catheter care 3x/wk x 9 wks

Specific services rendered by physical, speech, and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are for heat, sound, cold, and electronic stimulation.

EXAMPLE:

PT - To apply hot packs to the C5-C6 x 10 minutes 3x/wk x 2 wks
PRN visits may be ordered on a plan of care only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service must be specified. Open-ended, unqualified PRN visits do not constitute physician orders since neither their nature nor their frequency is specified.

EXAMPLE:

Skilled nursing visits 1xmx2m for Foley change and PRNx2 for emergency Foley irrigations and/or changes.
Skilled nursing visits 1xmx2m to draw blood sugar and PRNx2 to draw emergency blood sugar if blood sugar level is above 400.

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.

Examples of realistic goals:

- Independence in transfers and ambulation with walker.
- Healing of leg ulcer(s).
- Maintain patency of Foley catheter. Decrease risk of urinary infection.
- Achieve optimal level of cardiovascular status. Medication and diet compliance.
- Ability to demonstrate correct insulin preparation and administration.

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 4 weeks. Skilled nursing visits will be decreased to 3 x week at that time.

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

24. Physician's Name --Print the physician's name. **Omit 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. The physician must be qualified to sign the certification and plan of care in accordance with 42 CFR 424, Subpart B. Physicians who have significant ownership interest in or a significant financial or contractual relationship with an HHA may not establish or review a plan of care or certify or recertify the need for home health services. (See §234.6 for information about physician certification/recertification.)

25. Date HHA Received Signed POC.--Enter the date you received the signed POC from the attending/referring physician. Enter N/A if Item 27 (DATE) is completed.

26. Physician Certification.--This statement serves to verify that the physician has reviewed the plan of care and certifies to the need for the services.

27. Attending Physician's Signature and Date Signed.-- Do not predate the orders for the physician, nor write the date in this field. If the physician left it blank, enter the date you received the signed POC under Item 25. Do not enter "N/A." Submit an unsigned copy of the CMS-485. Retain the signed copy.

28. Penalty Statement.--This statement specifies the penalties imposed for misrepresentation, falsification, or concealment of essential information on the CMS-485.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION

(COMPLETE FOR INITIAL CLAIMS ONLY)

1. PATIENT'S LAST NAME	FIRST NAME M.I.	2. PROVIDER NO.	3. HICN
4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE
8. TYPE ☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10.TREATMENT DIAGNOSIS	11. VISITS FROM SOC.

12. PLAN OF TREATMENT FUNCTIONAL GOALS

GOALS *(Short Term)*

OUTCOME *(Long Term)*

PLAN

13. SIGNATURE *(professional establishing POC including prof. designation)*

14. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*

I CERTIFY THE NEED FOR THESE SERVICES FURNISHED UNDER THIS PLAN OF TREATMENT AND WHILE UNDER MY CARE ☐ N/A

15. PHYSICIAN SIGNATURE

16. DATE

17. CERTIFICATION

FROM THROUGH N/A

18. ON FILE *(Print/type physician's name)*

☐

20. INITIAL ASSESSMENT *(History, medical complications, level of function at start of care. Reason for referral.)*

19. PRIOR HOSPITALIZATION

FROM TO N/A

21. FUNCTIONAL LEVEL *(End of billing period)* PROGRESS REPORT ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. SERVICE DATES

FROM THROUGH

Form CMS-700-(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-700

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.

2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000)*.

3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.

4. **Provider Name** - Enter the name of the Medicare billing provider.

5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider.

6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.

7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).

8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).

9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.

10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia. If the same as the primary DX enter SAME.

11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*

12. **Plan of Treatment/Functional Goals** - Enter brief current plan of treatment goals for the patient for this billing period. Enter the major short-term goals to reach overall long-term outcome. Enter the major plan of treatment to reach stated goals and outcome. Estimate time-frames to reach goals, when possible.

13. **Signature** - Enter the signature *(or name)* and the professional designation of the professional establishing the plan of treatment.

14. **Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.

15. **Physician's Signature** - If the form CMS-700 is used for certification, the physician enters his/her signature. **If certification is required and the form is not being used for certification, check the ON FILE box in item 18.** If the certification is not required for the type service rendered, check the N/A box.

16. **Date** - Enter the date of the physician's signature only if the form is used for certification.

17. **Certification** - Enter the inclusive dates of the certification, **even if the ON FILE box is checked in item 18.** Check the N/A box if certification is not required.

18. **ON FILE** (Means certification signature and date) - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If certification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**

19. **Prior Hospitalization** - Enter the inclusive dates of recent hospitalization *(1st to DC day)* **pertinent** to the patient's current plan of treatment. Enter N/A if the hospital stay does not relate to the rehabilitation being rendered.

20. **Initial Assessment** - Enter only **current relevant history** from records or patient interview. Enter the major functional limitations stated, if possible, in objective measurable terms. Include only relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include only pertinent baseline tests and measurements from which to judge future progress or lack of progress.

21. **Functional Level** (end of billing period) - Enter the pertinent progress made and functional levels obtained at the end of the billing period compared to levels shown on initial assessment. Use objective terminology. Date progress when function can be consistently performed. When only a few visits have been made, enter a note indicating the training/treatment rendered and the patient's response if there is no change in function.

22. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

MEDICAID INSTRUCTIONS

FORM CMS 700-(11-91) "PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION"

Form CMS 700-(11-91), "PLAN OF TREATMENT FOR OUTPATIENT REHABILITATION" is a required attachment to the Medicaid Prior Authorization Form 1144. ("INSTRUCTIONS: PRIOR AUTHORIZATION FORM 1144", II. General Instructions, D.1, "Outpatient Physical Therapy, Occupational Therapy and Speech Therapy".)

If provider has submitted a Form CMS 700-(11-91) to Medicare for authorization, the MQD will accept a copy of the form in its entirety. If, however, the recipient is Medicaid only, please note the following:

- #2, #3, #5 have been omitted
- #8 refers to Hawaii Medicaid covered services PT, OT, SPL only.

Please complete the following fields of the Form CMS 700-(11-91) for initial outpatient rehabilitative services:

1. Patient's Last Name, First Name, M.I.
2. **Omit**
3. **Omit**
4. Provider Name
5. **Omit**
6. Onset Date
7. SOC Date
8. Type: PT, OT, SLP only **(Omit CR, RT, PS, SN, SW)**
9. Primary Diagnosis
10. Treatment Diagnosis
11. Visits from SOC
12. Plan of Treatment Functional Goals, including Goals *(Short Term)* and Outcome *(Long Term);* and Plan
13. Signature
14. Frequency/Duration
15. Physician Signature
16. Date
17. Certification
18. On File
19. Prior Hospitalization
20. Initial Assessment
21. Functional Level (omit "continue services or DC services")
22. Service Dates

** Detailed instructions are found in the attached **"INSTRUCTIONS FOR COMPLETION OF FORM CMS-701".**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

1. PATIENT'S LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN

4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE

8. TYPE	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A

15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-701

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.

2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000).*

3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.

4. **Provider Name** - Enter the name of the Medicare billing provider.

5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider. *(This is an item which you may enter for your own records.)*

6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.

7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).

8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).

9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.

10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia.
If the same as the primary DX enter SAMPLE.

11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*

12. **Current Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.

13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. *(If the same as shown on the CMS-700 or previous 701 enter "same".)* Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.

14. **Recertification** - Enter the inclusive dates when recertification is required, **even if the ON FILE box is checked in item 17.** Check the N/A box if recertification is not required for the type of service rendered.

15. **Physician's Signature** - If the form CMS-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box**. If the form CMS-701 is not being used for recertification, check the ON FILE box - item 17.** If discharge is ordered, check DC box.

16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.

17. **On File** *(Means certification signature and date)* - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**

18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the **major reasons** why the patient needs to continue skilled rehabilitation **for this billing period** (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician's recertification.

19. **Signature** - Enter the signature *(or name)* and the professional designation of the individual justifying or recommending need for care *(or discontinuance)* for this billing period.

20. **Date** - Enter the date of the rehabilitation professional's signature.

21. Check the box if services are continuing or discontinuing at end of this billing period.

22. **Functional Level** *(end of billing period)* - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous CMS-701, item 22, or the CMS-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when significant regression in function occurs. Your intermediary reviews this progress compared to that on the prior CMS-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.

23. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.

MEDICAID INSTRUCTIONS

FORM CMS 701-(11-91) "UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION"

Form CMS 701-(11-91), "UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION" is a required attachment to the Medicaid Prior Authorization Form 1144. ("INSTRUCTIONS: PRIOR AUTHORIZATION FORM 1144", II. General Instructions, D.1., "Outpatient Physical Therapy, Occupational Therapy and Speech Therapy".)

If provider has submitted a Form CMS 701-(11-91) to Medicare for extended authorization, the MQD will accept a copy of the form in its entirety. If, however, the recipient is Medicaid only, please note the following:

- #2, #3, #5 have been omitted
- #8 refers to Hawaii Medicaid covered services PT, OT, SPL only

Please complete the following fields of the Form CMS 700-(11-91) for additional outpatient rehabilitative services:

1. Patient's Last Name, First Name, M.I.
2. **Omit**
3. **Omit**
4. Provider Name
5. **Omit**
6. Onset Date
7. SOC Date
8. Type: PT, OT, SLP only **(Omit CR, RT, PS, SN, SW)**
9. Primary Diagnosis
10. Treatment Diagnosis
11. Visits from SOC
12. Frequency/Duration
13. Current Plan Update, Functional Goals, including Goals *(Short Term)* and Outcome *(Long Term);* and Plan
14. Recertification, if applicable
15. Physician's Signature
16. Date
17. On File
18. Reason(s) for Continuing Treatment This Billing Period
19. Signature Prior Hospitalization
20. Date
21. Continue services or DC services
22. Service Dates

******Detailed instructions are found in the attached **"INSTRUCTIONS FOR COMPLETION OF FORM CMS-701".**

DEPARTMENT OF HUMAN SERVICES

Return to: DHS/Med-QUEST Division
Medical Standards Branch
P. O. Box 339
Honolulu, HI 96809-0339

CENSUS REPORT

Medicaid Resident Movement

FACILITY NAME	PERIOD COVERED
_____	From: ___/___/___ To: ___/___/___ (mm/dd/yy) (mm/dd/yy)

TYPE OF REPORT (Check only one) _____ **MONTHLY** _____ **QUARTERLY**

GENERAL INSTRUCTIONS:

- Please **PRINT/TYPE** all information.
- **Submit a Monthly** report each month.
- **Reports due** by 15 of following month.
- **Submit Monthly and Quarterly (an alphabetical list) of all Medicaid residents in-house on March 31, June 30, September 30, and December 31.**

MEDICAID RESIDENT (List Last Name, First Name)	MEDICAID (HMSA) ID No.	FOR MONTHLY Admission Date To Facility	Admission Date To Medicaid	LOA	D	E	Date of Action *	REMARKS **
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								
16.								
17.								
18.								
19.								
20.								
21.								
22.								
23.								
24.								
25.								

THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE FOR THE REPORTING PERIOD.

_____ Signature/Title

_____ Date

* DATE OF ACTION for Level of Acuity (LOA) Change, Discharge(D) or Expiration (E).

** REMARKS, i.e., Admit from, Discharged to, LOA change
(A = ICF, B = ICF/MR, C = SNF)

DHS 1137(Rev. 11/96) Original- MQD/MSB Copy Copy # 2 - Fiscal Intermediary Copy # 3 - Facility Copy

DEPARTMENT OF HUMAN SERVICES
Med-Quest Division, Medical Standards Branch [FAX # (808) 692-8131]

P. O. Box 700190
Kapolei, HI 96707

INCIDENT REPORT

Reportable incident: (Submit within 72 hours of reportable incident.) Check appropriate box below.

[ ] Absence without leave for one or more nights.
[ ] Adverse reaction to a drug, medication error and/or treatment.
[ ] Bodily injury requiring medical intervention.

1.Facility Name			
2. Resident Name	**3. Sex**	**4. Birthdate(mm/dd/yyyy)**	**5. Acuity Level at time of incident [ ]SNF [ ]ICF [ ]ICF/MR [ ]Other**
6. Diagnosis(ses)			
7. Date & Time of incident	**8. Place of incident (e.g., hallway, bedroom, dining area, etc.)**		

(Note: If more space is needed, continue at the back of this form.)
8. Description of incident:

9. Description of the kind & extent of medical intervention: (Include/attach results of diagnostic tests; e.g., xrays, M.D. assessment, etc.)

10. Corrective action(s):

11. Reported to other agency(ies); e.g., APS, DOH, MID: Yes [ ]_____ **No [ ]**
Name(s)

12. Name & Title of reporter: _____

_____ _____
Signature Date

13. If NO reportable incidents have occurred in the facility from Jan.- June or July - Dec., pls. complete below and submit by the 15th of the month following the end of the reporting period.

NO REPORTABLE INCIDENT: [ ] Jan. – June, Year _____ [ ] July – Dec., Year _____

Name & Title of reporter: _____ **Facility Name:** _____

_____ **Date:** _____
Signature

DHS 1147i (2/2000) DO NOT MODIFY FORM

INSTRUCTIONS
DHS 1147i

INCIDENT REPORT

Reportable Incident:		Check appropriates Box (es).
1.	Facility Name:	Self-explanatory
2.	Resident Name:	Self-explanatory
3.	Sex:	Self-explanatory
4.	Birthdate:	Self-explanatory
5.	Acuity Level at Time of Incident:	Check the appropriate level. If you check "Other", specify the level; e.g., Subacute.
6.	Diagnosis(ses):	List major diagnoses.
7.	Date & Time of Incident:	Self-explanatory.
8.	Place of Incident:	Self-explanatory.
9.	Description of Incident:	Describe how the incident occurred. Include names and titles of persons involved.
10.	Description of the Kind & Extent of Medical Intervention:	Describe fully. If unable to provide result(s) of Diagnostic test(s) on the Incident Report, explain why. Results should then be submitted as soon as possible.
11.	Corrective Action:	Specify corrective measures done or put in place to ensure that such incident(s) will not recur and indicate how the facility will monitor its corrective actions.

12. Reported to Other Agency(ies): Check "YES" or "NO". If "YES", specify the agency(ies) reported to.

13. Name and Title of Reporter: Self-explanatory.

14. If NO reportable incidents have occurred in the facility from January–June or July–December, please complete the information below and submit it by the 15th of the month following the end of the reporting period: Self-explanatory.

STATE OF HAWAII

Department of Human Services **Med-QUEST Division**

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) **LEVEL I SCREEN**	**PATIENT'S NAME: (Last Name, First, M.I.)**	**DATE OF BIRTH: (MM/DD/YY)**
	PRIMARY DIAGNOSIS:	**MEDICAID I.D. NUMBER:**
	REFERRAL SOURCE: (Physician's Name; Nursing Facility; Hospital; Etc.)	

PART A: SERIOUS MENTAL ILLNESS (SMI): **YES** **NO**

1. The individual has a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal): ( ) ( )

   a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**

   b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**

2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam. ( ) ( )

3. Has psychoactive drug(s) been prescribed on a regular basis for the individual within the last two (2) years with or without current diagnosis of SMI ? ( ) ( )

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD): **YES** **NO**

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18. ( ) ( )

2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: _____ ( ) ( )

3. Does the ID/DD individual have a primary diagnosis or presence of **Dementi** yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available. ( ) ( )

4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently). ( ) ( )

5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD _____ ( ) ( )

_____

DETERMINATION:

1. If any of the answers in Parts A or B are **YES, COMPLETE PART C (page 2)** of this form.
2. If all of the answers in Parts A or B are **NO, SIGN** and **DATE** BELOW:

LEVEL I SCREEN IS NEGATIVE FOR SMI OR ID/DD THE PATIENT MAY BE ADMITTED TO THE NF:	**DATE AND TIME COMPLETED:**
_____	_____
SIGNATURE OF PHYSICIAN, APRN, RN	**MM/DD/YY**
_____	_____
PRINT NAME	**Time**

PART C:		**YES**	**NO**
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less)** and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual require **provisional admission which is <u>not to exceed 7 days,</u>** for further assessment in emergency situations that require protective services?	**( )**	**( )**
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? <u>The individual is expected to return to the same caregivers following this brief NF stay.</u>	**( )**	**( )**

……...

<u>CHECK ONLY ONE:</u>

[ ] If **any** answer to Part C is **Yes, NO <u>REFERRAL for LEVEL II</u>** <u>evaluation and determination is necessary at this time.</u> **<u>NOTE TIME CONSTRAINTS!</u>**

[ ] If **all** answers to Part C are **No, <u>REFERRAL for LEVEL II</u>** <u>evaluation and determination</u> **<u>MUST BE MADE.</u>**

SIGN and DATE this form.

	DATE & TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, RN	**MM/DD/YY**
PRINT NAME	**TIME**

1.0 PAS/RR OVERVIEW

The Omnibus Budget Reconciliation Act (OBRA) 1987 (P.L. 100-203) established requirements for Preadmission Screening and Annual Resident Review (PAS/RR), These requirements are:

- Nursing facilities must not admit, on or after January 1, 1989 any new individual who has intellectual disabilities (ID) or a related developmental disability disorder (DD), or a serious mental illness (SMI) unless the state mental health authority or intellectual disabilities authority has determined, prior to admission, that the individual requires the level of services provided by a NF and if so, whether the individual requires specialized services:

- The PAS/RR determinations must follow established criteria developed by the Secretary; and

- NFs through the MDS process will identify and refer residents who have a significant change that results in a new suspected diagnosis of mental illness or intellectual disability or in a change in the previous determinations concerning specialized services needs or NF level of care.

FAILURE TO MEET THE ABOVE REQUIREMENTS IS SUBJECT TO NON-PAYMENT OR RECOVERY OF PAYMENT FOR SERVICES UNTIL COMPLIANCE IS ACHIEVED.

PAS/RR is a requirement for NF Medicaid participation and, therefore, a NF is subject to withdrawal or recovery of Medicaid payment or decertification action for failure to perform PAS/RR for all individuals.

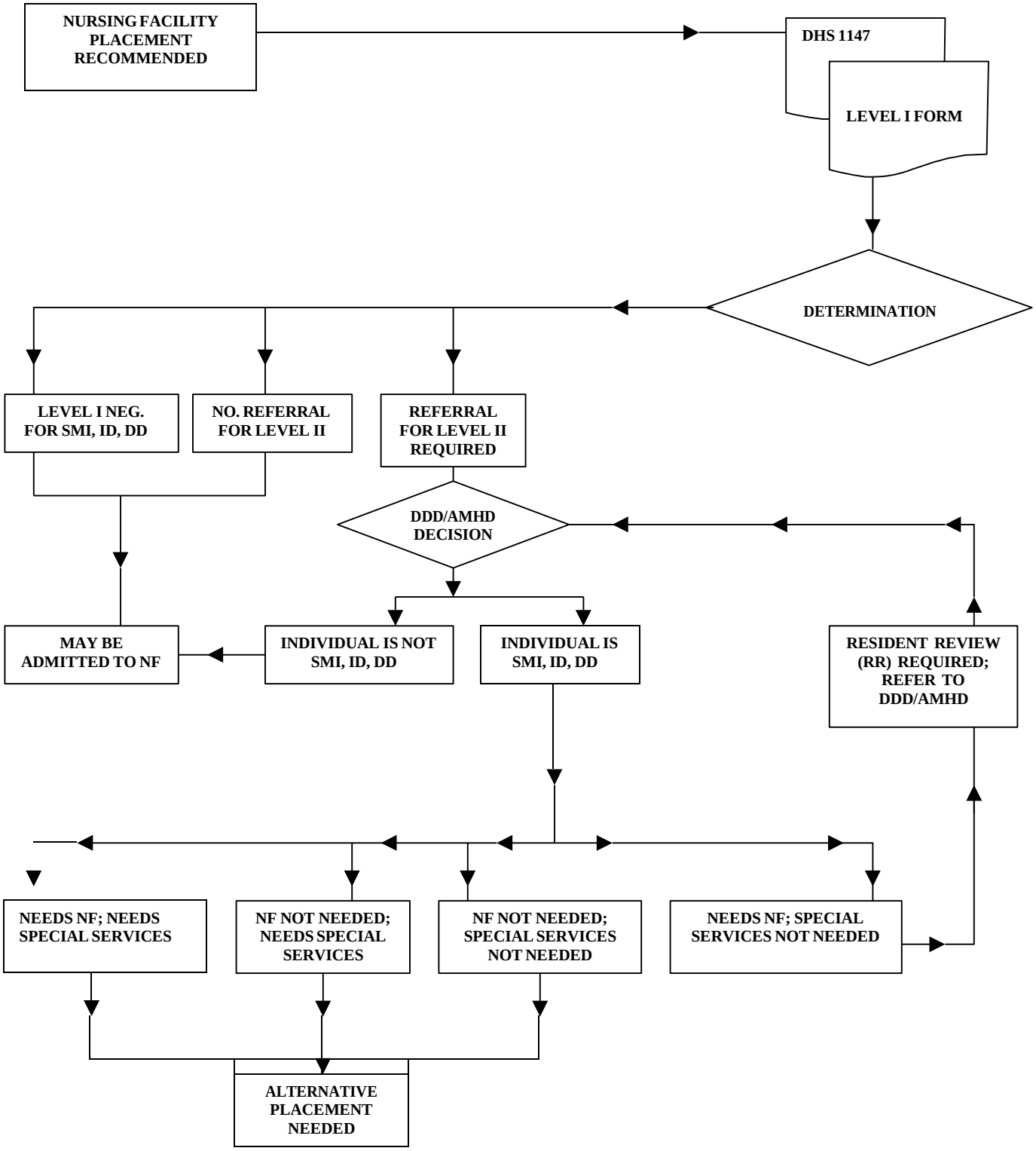
PAS/RR involves three distinct processes:

1. Level I requires the identification of individuals subject to PAS/RR;

2. Level II requires the performance of evaluations and determinations by the Adult Mental Health Division (AMHD) or the Developmental Disabilities Division (DDD); and

3. Resident Reviews requires referrals of residents that has a significant change that results in a new suspected diagnosis of mental illness or intellectual disability or in a change in the previous determinations concerning specialized services needs or NF level of care.

P A S / R R P R O C E S S



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3. Resident Reviews requires referrals of residents that has a significant change that results in a new suspected diagnosis of mental illness or intellectual disability or in a change in the previous determinations concerning specialized services needs or NF level of care.

2.0 DEFINITIONS

DEMENTIA

The individual has a current diagnosis of dementia (including Alzheimer's disease or a related disorder as defined in the current DSM-III-R. The following other criteria to be applied include:

1. Diagnostic criteria such as global impairments of cognitive functioning, personality changes and disturbances in behavior and affect, and in social and occupational functioning are met; and

2. Collaborative evidence from the history, physical examination, or laboratory tests to support the diagnosis exists. In the absence of such evidence an organic factor can be presumed if the disturbance cannot be accounted for by a functional mental disorder.

EXEMPTED HOSPITAL DISCHARGE

An individual admitted to any NF directly from a hospital, requires NF services for the condition for which he or she received care in the hospital and whose attending physician certifies before admission to the NF that less than a thirty (30) day stay is required.

INTERFACILITY TRANSFER

An interfacility transfer occurs when an individual is transferred from one NF to another NF with or without an intervening hospital stay.

MDS/RAI

Refers to the Minimum Data Set/Resident Assessment Instrument.

INTELLECTUAL DISABILITIES

Intellectual disabilities refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period:

General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;

Significantly subaverage intellectual functioning is defined as approximately IQ 70 or below;

Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group; and

Developmental period as defined as the period of time between birth and the 18th birthday.

NEW ADMISSION

An individual admitted to any NF for the first time and does not qualify as a readmission.

PERSONS WITH RELATED CONDITIONS (DEVELOPMENTAL DISABILITIES)

Persons with related conditions have a severe, chronic disability attributable to a mental or physical impairment or a combination of mental and physical impairments and which:

1. Is manifested before the person reaches age 22 years;

2. Is likely to continue indefinitely;

3. Results in substantial functional limitations in three (3) or more of the following areas of major life activity:

    - mobility
    - self care/direction
    - understanding and use of language
    - learning
    - understanding/use of language
    - capacity for independent living

4. Reflects the person's need for a combination and sequence of special interdisciplinary or generic care treatment or other services which are individually planned and coordinated.

PSYCHOACTIVE DRUGS

Refers to drugs that affect the mind and behavior and include the following classes:

- anti-psychotic;
- anti-depressant; and
- anti-anxiety drugs.

NOTE: The use of a psychoactive drug on a regular basis in the absence of a neurological disorder is an indication that Level II screening is necessary. However, evidence of psychoactive drug use alone need not be taken as an indication that further review is needed when there is a medical diagnosis and justification for its use that is not in connection with a mental disorder. For example, the use of Valium as an adjunct in seizure disorders.

READMISSION

An individual readmitted to a NF from a hospital to which he or she was transferred for care.

SERIOUS MENTAL ILLNESS

An individual is considered to have a serious mental illness (SMI) if the following requirements on diagnosis, level of impairment and duration of illness are met:

1. **Diagnosis** – The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders (DSM) 3rd Edition, revised in 1987 (See Appendix A). This mental disorder is:

   a. A schizophrenic, mood, delusional (paranoid), panic and other severe anxiety disorder, somatoform disorder, personality disorder, substance related or psychotic disorder not elsewhere classified that may lead to a chronic disability; but

   b. Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder.

2. **Level of impairment** – The disorder results in functional limitations in major life activities within the past 3 to 6 months. Examples of major life activities of daily living include:

   - Eating, bathing, dressing;
   - Instrumental activities of daily living (maintaining a household, using money, using public transportation;
   - Functioning in social, family and vocational/educational contexts; and
   - Coping skills and stress tolerance.

   Adults who would have met functional impairment criteria during the reference year without treatment or other support services are considered to have serious mental illness.

3. **Recent treatment** – Treatment history indicates that the individual has experienced at least one of the following:

a. Psychiatric treatment more intensive than outpatient care more than once in the past two (2) years (e.g., partial hospitalization or inpatient hospitalization); or

b. Within the past two (2) years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home or in an individual treatment environment, or which resulted in intervention by housing or law enforcement officials.

SPECIALIZED SERVICES FOR INTELLECTUAL DISABILITIES

Services specified by the State combined with services provided by the NF which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

1. The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible; and

2. The prevention or deceleration of regression or loss of current optimal functional status.

Specialized services do not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous program.

SPECIALIZED SERVICES FOR SMI

1. For individuals with SMI it is the continuous and aggressive implementation of an individualized plan of care that:

   a. Is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals;

   b. Prescribes specific therapies and activities for the treatment of individuals experiencing an acute episode of severe mental illness, which necessitates twenty-four (24) hour supervision by trained mental health personnel in an institution; and

   c. Is directed toward diagnosing and reducing the individual's psychotic symptoms that necessitated institutionalization, improving his/her level of independent functioning and achieving a functioning level that permits reduction in the intensity of mental health services below the level of specialized services at the earliest possible time.

2. For individuals with ID/DD it is a continuous treatment program which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

   a. The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible;

b. The prevention or deceleration of regression or loss of current optimal functional status; and

c. Does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program.

3.0 LEVEL I – PAS/RR

The Level I process is a set of activities designed to determine individuals who are subject to PAS/RR. The process involves the identification of persons suspected of having SMI (serious mental illness) or ID/DD (intellectual disabilities/developmental disability) which would require further screening.

REQUIREMENT

All individuals (regardless of payment source and known diagnoses) who apply as a new admission to a Medicaid certified NF after January 1, 1989 shall have a "Preadmission Screening Annual Resident Review (PAS/RR) Level I Screen for SMI or ID/DD" form completed.

EXCEPTIONS

1. Acute care patients who are admitted to a NF directly from the hospital for continuing care for their acute care condition and the attending physician certifies prior to admission that they will require less than thirty (30) days of care in the NF;

2. Individuals readmitted to NF from a hospital to which he or she was transferred for care; and

3. Individuals transferred from one NF to another NF with or without an intervening hospital stay. **The transferring facility is responsible for ensuring that PASRR and a copy of the most recent RAI reports accompany the transferring resident.**

PROCESS AND PROCEDURES

PROCESS	PROCEDURES	RESPONSIBLE AGENCY
3.1 Apply for NF Admission.	When the attending physician determines that the individual requires admission to a NF, DHS Form 1147 is required for individuals with Medicaid as primary payor. See Appendix C, "Criteria for Approval of NF Services."	Attending physician
3.2 Screen individuals to identify who is subject to PAS/RR.	The form, Preadmission Screening Annual Resident Review (PAS/RR) Level I Screen, must be completed for all NF applications for admission. **However, a Level I form need not be completed for the three-(3) exceptions noted above.** Instructions on completion of the form may be found in Appendix B. Review the Level I screening form to assure completeness, accuracy, and consistency with available reports and assessments and the established definitions and criteria are met. Incomplete or inaccurate Level I documents should be returned to the originator for completion, correction or clarification.	Attending MD, social services or discharge planner or facility designee

PROCESS	PROCEDURES	RESPONSIBLE AGENCY
3.3 Admit to NF	A check mark on Level I form that indicates the Level I screening was negative for SMI/ID means the individual may be admitted to a NF.	Admitting NF
	A check mark on the Level I form that indicates a Level II screening is not needed at this time also means the individual may be admitted to a NF. The exceptions from referral for Level II are listed in the section Level II PAS/RR.	Admitting NF
	When the individual is admitted to a NF (**new admissions only**), a copy of the Level I document must be submitted with the census report.	Admitting NF
	The original Level I document must be retained in the individual record.	Admitting NF
3.4 PAS/RR Level II needed	A check mark on the Level I form that indicates Level II screening is required shall be referred to the appropriate authority.	Requesting agency, social services or discharge planner in acute hospital
	For persons with a dual diagnosis (ID and SMI) referrals to both authorities must be made concurrently.	Same as above
	Provide written notice to the individual and his legal representative that the individual is suspected of having SMI/ID/DD and is being referred to AMHD or DDD or both.	

3.0 LEVEL II – PAS/RR

PURPOSE

The Level II process involves two (2) distinct activities. The first process involves the performance of necessary evaluation(s) and the second process requires a determination of need for NF placement and specialized services.

REQUIREMENTS

All individuals (regardless of payment source) suspected as having ID/DD on the Level I screening form shall be referred to the Department of Health/Developmental Disabilities Division (DOH/DDD) for diagnostic evaluation and determination of need for NF services and Specialized services.

All individuals (regardless of payment source) suspected as having SMI shall be referred to the Department of Health/Adult Mental Health Division (DOH/AMHD) for the determination of need for NF services and specialized services.

EXCEPTIONS

The following SMI or ID/DD individual, who is not a danger to self or others and requires NF level of services; but, does not require specialized services need not be referred for LEVEL II evaluation and determination:

1. An individual who requires **convalescent care** from an acute physical illness that required hospitalization and does not meet all the criteria for an exempt hospital discharge may be admitted to a NF for a period not to exceed one-hundred and twenty (120) days as part of a medically prescribed period of recovery from an acute physical illness;

2. An individual who is certified by a physician to be **terminally ill** with a medical prognosis for life expectancy of six (6) months or less;

3. An individual who has a severe physical illness such as **coma, ventilator dependence,** functioning at a brain stem level, or diagnoses such as **chronic obstructive pulmonary disease, Parkinson's Disease, Huntington's Disease, amyotrophic lateral sclerosis and congestive heart failure** which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services;

4. **Provisional admissions** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears;

5. **Provisional admissions not to exceed seven (7) days** for further assessment for emergency situations requiring protective services; and
6. Individuals admitted for very brief stays up to thirty (30) days to provide **respite** to caregivers to whom the individual is expected to return following the NF stay.

PROCESS AND PROCEDURES

PROCESS	PROCEDURES	RESPONSIBLE AGENCY
4.1 Refer for Level II	Refer individuals that meet the definitions and criteria of ID/DD to: Developmental Disabilities Division Department of Health 3627 Kilauea Avenue, Room 104 Honolulu, Hawaii 96816 Stephanie Guieb, RN Phone: (808) 733-9177 Fax: (808) 733-9182 Refer individuals that meet the definitions and criteria for SMI to: Adult Mental Health Division Department of Health 2385 Waimano Home Road, Building 4, Pearl City, HI 96782 Dr. James Westphal Phone: (808) 453-6922 Fax: (808) 453-6995	Referring agency, hospital, attending physician Same as above
4.1 Continue	Utilize the process and procedures established by AMHD and/or DDD to make the referral. To assure Medicaid reimbursement for psychiatric evaluations for PAS/RR, instruct the psychiatrist performing the evaluation to use the CPT code 90801 with the modifier code X9 when submitting a Medicaid claim. When all efforts to arrange for a psychiatric evaluation have been exhausted, call: Department of Human Services Med-QUEST Division Health Care Services Branch Contract Monitoring and Compliance Section Phone: (808) 692-8174	Same as above Same as above Same as above

PROCESS	PROCEDURES	RESPONSIBLE AGENCY
4.2 Determination	DOH/AMHD and DOH /DDD must make the following written determinations (using forms described in the policy and procedures of DDD and AMHD): - the individual is or is not SMI/ID/DD; - the individual requires or does not require specialized services; and NF placement is or is not appropriate. See Appendix C "Criteria for Approval of NF services."	AMHD/DDD
4.2 Continue	The written notice shall be sent to the following individuals: - the evaluated individual and his or her legal representative; - the admitting NF or retaining NF; - the attending physician; and - the discharging hospital. The notice shall include: - whether NF level of services is needed; - whether specialized services are needed; - the placement options that are available consistent with the determination ; and - **the right of the individual to appeal the determination.** PASRR determinations made by DOH/AMHD and DOH/DDD cannot be counter-manded.	Same as above Same as above

PROCESS	PROCEDURES	RESPONSIBLE AGENCY
4.3 Appeal	If the individual or his/her legal representative requests an appeal of the determination, the DOH/AMHD or DOH/DDD appeal process shall be used. See Appendix D. If determinations are upheld, proceed to step 4.4 If determinations are not upheld, proceed to step 4.5 If no written request for an appeal of the determination is made, proceed to step 4.4 If determinations are not upheld, proceed to step 4.5. If no written request for an appeal of the determination is made, proceed to step 4.4	AMHD/DDD
4.4 Implement Appropriate Placement	Proceed with appropriate placement for individual based on the following determination findings. If the determination indicates that NF placement is not needed, the applicant cannot be admitted to a NF. Alternative placement options should be discussed with the individual and his/her representative. If the written notice of determination indicates that NF level of service is needed and specialized services are <u>not</u> needed, individual may be admitted to a NF. If NF placement is needed and the individual also requires specialized services, individual may <u>not</u> be admitted to a NF. AMHD/DDD will coordinate with the referring agency for placement. All evaluation and determination documents must be retained in the individual record. Upon admission to a NF submit a copy of the written determination, the Level I document and all evaluations with the census report should be explored.	Referring agency or attending physician AMHD/DDD Admitting NF
4.5 Follow-up of Appeal. Admit to NF	If the findings of the appeal officer do not uphold determinations, the recommendations of the appeal officer shall be implemented.	Admitting NF