Patient Plans of Care for Long Term Care

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Institutional providers such as Nursing Facility Level A (NF-A) and Nursing Facility Level B (NF-B) must include a written plan of care in each patient's medical record.

Note: Nursing Facility Level A (NF-A) replaces Intermediate Care Facility (ICF) references, and Nursing Facility Level B (NF-B) replaces Skilled Nursing Facility (SNF) references.

Code of Federal Regulations (CFR), Title 42, Section 440.155(a)(1) defines nursing facility services as those provided in a facility that "fully meets the requirements for a State license to provide, on a regular basis, health-related services to individuals who do not require hospital care, but whose mental or physical condition requires services that – (i) are above the level of room and board; and (ii) can be made available only through institutional facilities[.]"

Federal law allows continuity of care protections for individuals to receive medically necessary intermediate care services at the NF-B where they are receiving medically necessary skilled nursing services. If a Medi-Cal recipient needs intermediate care services, but the NF-B facility is not licensed to provide intermediate care, the facility can arrange for transfer to a facility that provides intermediate care services if the recipient is ready for transfer and there are beds available in that facility. While the recipient is awaiting transfer, the NF-B shall continue to provide medically necessary services to the recipient until another facility is available.

Requirements

Individual written plans are required by *Code of Federal Regulations* (CFR), Title 42, to be approved and signed by a physician. Plans should include:

- Diagnosis, symptoms, complaints and complications;
- Description of individual's functional level;
- Objectives;
- Orders for medication, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures;
- Plans for continuing care; and
- Plans for discharge.

State reviewers will monitor federal requirements during onsite and/or annual medical reviews.

CFR, Title 42

Providers can refer to the following CFR, Title 42, sections pertaining to Plans of Care:

‹‹**CFR, Title 42 Plans of Care Table**››

Skilled Nursing Facilities	Section 456.280
Intermediate Care Facilities including Special Treatment Program, Intermediate Care Facilities/ Developmentally Disabled, and Intermediate Care Facilities/ Developmentally Disabled-Habilitative	Section 456.380

or, note the following summary of CFR, Title 42:

Nursing Facility Level B Written Plan of Care

I. The Skilled Nursing Facility Written Plan of Care (includes distinct parts of acute hospitals and NF-Bs)

(a) Before admission of a patient to an NF-B or before authorization for payment, the attending physician must establish a written Plan of Care for each applicant or recipient in an NF-B.

(b) The Plan of Care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any orders for –

i. Medications,

ii. Treatments,

iii. Restorative and rehabilitative services,

iv. Activities,

v. Therapies

vi. Social services

vii. Diet, and

viii. Special procedures recommended for the health and safety of the patient;

(5) Plans for continuing care, including review and modification to the Plan of Care; and

(6) Plans for discharge.

(c) The attending or staff physician and other personnel involved in the recipient's care must review and sign each Plan of Care at least every 60 days.

Nursing Facility Level A Written Plan of Care

II. The Intermediate Care Facility Written Plan of Care (includes ICF/DD and ICF/DD-H)

(a) Before admission of a patient to an NF-A or before authorization for payment, a physician or staff physician must establish a written Plan of Care for each applicant or recipient.

(b) The Plan of Care must include:

(1) Diagnoses, symptoms, complaints, and complications indicating the need for admission;

(2) A description of the functional level of the individual;

(3) Objectives;

(4) Any orders for –

i. Medications,

ii. Treatments,

iii. Restorative or rehabilitative services,

iv. Activities,

v. Therapies,

vi. Social services,

vii. Diet, and

viii. Special procedures designed to meet the objective of the Plan of Care;

(5) Plans for continuing care, including review and modification to the Plan of Care; and

(6) Plans for discharge.

(c) The team must review and sign each Plan of Care at least every 90 days.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
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