G572

(Rev. 182, Issued: 09-28-18, Effective: 09-28-18, Implementation: 09-28-18)

§484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

Interpretive Guidelines §484.60(a)(1)

"Patient-specific measurable outcome" is a change in health status, functional status, or knowledge, which occurs over time in response to a health care intervention that provides end-result functional and physical health improvement/stabilization.

Patient-specific goals must be individualized to the patient based on the patient's medical diagnosis, physician's orders, comprehensive assessment and patient input. Progress/non-progress toward achieving the goals is evaluated through measurable outcomes. The HHA must include goals for the patient, as well as patient preferences and service schedules, as a part of the plan of care (See §484.60(a)(2) below).

"Periodically reviewed" means every 60 days or more frequently when indicated by changes in the patient's condition (see §484.60(c)(1)).

The patient's physician orders for treatments and services are the foundation of the plan of care. If the HHA misses a visit or a treatment or service as required by the plan of care, which results in any potential for clinical impact upon the patient, then the HHA must notify the responsible physician of such missed treatment or service. The physician decides whether the treatment or service may be skipped or whether additional intervention is required by the HHA due to the clinical impact on the patient.

If the patient or the patient's representative refuses care that could impact the patient's clinical wellbeing (such as dressing changes or essential medication) on more than one occasion, then the HHA must attempt to identify the reason for the refusal. If the HHA is unable to identify and address the reason for the refusal, then the HHA must communicate with the patient's responsible physician to discuss how to proceed with patient care.

The physician should not be approached to reduce the frequency of services based solely on the availability of HHA staff.

In instances where the HHA receives a general referral from a physician that requests HHA services but does not provide the actual plan of care components (i.e., treatments and observations) for the patient, the HHA will not be able to create a comprehensive plan of care to include goals and services until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician.