WISCONSIN MEDICAID UPDATE

JANUARY 9, 1995

UPDATE 95-2

TO:
Home Health Agencies
Personal Care Agencies
Nurses In Independent Practice

New HCFA-485/486 Forms

Medicare Home Health Agency Manual (HCFA-Pub. 11) Transmittal No. 272, dated September 1994, provides information about the revised HCFA-485, Home Health Certification and Plan of Care, and HCFA-486, Medical Update and Patient Information.

We will accept either the old or the new forms through June 30, 1995. On and after July 1, 1995, we will only accept HCFA-485 and HCFA-486 forms with a 2-94 edition date. This long phase-in period will allow providers to use up supplies of the old forms.

When completing the HCFA forms, you must use both the instructions located in Medicare Transmittal No. 272 and in Appendix 5 of the handbook for home health agencies (Part L, Division II). Please update Appendix 5 instructions as follows:

HCFA-485

- Under item 3, change Locator 4 to Locator 14.
- Under item 7, change Locator 20 and 21 to Locator 19 and 20.

HCFA-486

- Delete item 2, since Locator 13 has been deleted.
- Delete item 3. Delegating nurse is monitored through surveys and audits.

Copies of the new forms are attached. You may photocopy them for your use.

Personal care agencies and nurses in independent practice:
You have the option of using the HCFA-485 and HCFA-486 forms for physician orders. These forms may help you submit complete prior authorization requests. These forms are available from most office supply stores (the forms are not available from our fiscal agent). If you need help completing the forms, you may contact Gail Boushon, Home Care Analyst, at (608) 266-0511.

Department of Health and Human Services
Health Care Financing Administration

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.

Form HCFA-485 (C-4) (02-94) (Print Aligned)

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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

Public reporting burden for this collection of information is estimated to average 15 minutes per response and recordkeeping burden is estimated to average 15 minutes per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Health Care Financing Administration, P.O. Box 26684, Baltimore, Maryland 21207, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503. Paperwork Reduction Project 0938-0357.

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Health Care Financing Administration

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MEDICAL UPDATE AND PATIENT INFORMATION

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

6. Patient's Name and Address

7. Provider's Name

Medicare Covered: ☐ Y ☐ N | 9. Date Physician Last Saw Patient: | 10. Date Last Contacted Physician:

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N ☐ Do Not Know

12. ☐ Certification ☐ Recertification ☐ Modified

13. Dates of Last Inpatient Stay: Admission Discharge

14. Type of Facility:

15. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

16. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

17. Supplementary Plan of Care of File from Physician Other than Referring Physician: ☐ Y ☐ N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

18. Unusual Home/Social Environment

19. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

20. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

21. Nurse or Therapist Completing or Reviewing Form | Date (Mo., Day, Yr.)

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