

Beneficiary Name: _____ **Medicaid#:**

Diagnoses and ICD-9-CM Codes <i>(Do not complete this section upon precertification)</i>																		
	<i>Description (e.g. Medical - CVA, Therapy - paralysis of lower limb)</i>	<i>ICD-9-CM Codes:</i>																
Medical Diagnoses:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Therapy Diagnoses:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> <td style="width: 15%;"><input type="text"/></td> </tr> <tr> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Procedure/Modality:	CPT Code	Units		Frequency (# per week, day, month)	Duration (# of days, weeks, months)	Projected Period of Treatment (From/Thru)	
		Per Visit	Total				

I. Clinical Updates/Precautions *(General summary – attendance, general progress, set backs, or changes since last POC):*

II. Short Term Goals: *(Adult 1 month, Child 1-3 months) [specific, measurable, age appropriate, current status (baseline) for each goal]*

III. Long Term Goals: *(Adult 4-8 weeks, Child 3-6 months) [specific, measurable, age appropriate, current status (baseline) for each goal]*

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IV. Home Program/Caregiver (CG) Response: *[Describe Home Exercise Program (HEP), including frequency that HEP is to be performed. Indicate responsible caregiver and his/her response (i.e. ability to perform return demo, verbalization of understanding, and for concurrent review, list frequency that CG performed HEP). If applicable, document reasons explaining CG's inability to participate.]*

V. Discharge Plan:

Therapist Section

Documentation of Prescribing Provider's Verbal Order.
This Plan of Care must be reviewed and agreed to by the prescribing provider before treatment is begun.
Verbal order from _____, Title _____
Taken by _____, Title _____ Date _____

A therapy provider who knowingly or willfully makes, or causes to be made, any false statement of representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws and/or may be subject to civil monetary penalties and/or fines. I certify that I am the therapy provider who developed this plan of care. I certify that the information provided on the Plan of Care form is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution, or disqualify me as a provider of Medicaid services.

Signature and Title of Speech Language Pathologist _____
Date

Prescribing Provider Section

Prescribing Provider Attestation, Signature and Date *(Note: Must be completed before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan.)*

A physician, nurse practitioner, or physician assistant who attests to the medical necessity of the prescribed services, who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to monetary penalties and/or fines. I hereby certify that I have reviewed and approved this plan of care for the therapy provider and that I deem it to be medically necessary for the patient listed on this Plan of Care form. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Signature and Title of Prescribing Provider _____
Date

HealthSystems of Mississippi
175 E. Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201

HealthSystems of Mississippi
Speech Language Pathology Plan of Care
Addendum Page

Beneficiary Name: _____ **Medicaid#:**

Important Notice: When entering information on the Addendum Page, please reference the appropriate section.
(For Example: II. Recent Hospitalizations/Dates: ORIF right arm on 07/01/06)