

## Monthly Home Health Care Tracking

Patient Name: \_\_\_\_\_

Agency: \_\_\_\_\_

Month/Year: \_\_\_\_\_

Diagnoses: \_\_\_\_\_

Date

	<input type="checkbox"/> <b>G0180</b>	Developed care plan for Home Health Certification  Date of last face-to-face encounter: _____	<i>Do not include time in Care Plan Oversight</i>  <b>Attach Certification</b>
	<input type="checkbox"/> <b>G0179</b>	Reviewed care plan and Recertified patient for Home Health  Date of last face-to-face encounter: _____	<i>Do not include time in Care Plan Oversight</i>  <b>Attach Recertification</b>

### Care Plan Oversight Services

Date/Notes		Time Involved
	<input type="checkbox"/> Discuss patient care with other health care professionals <input type="checkbox"/> Review new information such as labs, wounds <input type="checkbox"/> Modify care plan <input type="checkbox"/> Change prescriptions, other therapy orders <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Document in patient chart.	<input type="checkbox"/> 5 minutes <input type="checkbox"/> 10 minutes <input type="checkbox"/> 15 minutes <input type="checkbox"/> 20 minutes <input type="checkbox"/> 25 minutes <input type="checkbox"/> 30 minutes <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Discuss patient care with other health care professionals <input type="checkbox"/> Review new information such as labs, wounds <input type="checkbox"/> Modify care plan <input type="checkbox"/> Change prescriptions, other therapy orders <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Document in patient chart.	<input type="checkbox"/> 5 minutes <input type="checkbox"/> 10 minutes <input type="checkbox"/> 15 minutes <input type="checkbox"/> 20 minutes <input type="checkbox"/> 25 minutes <input type="checkbox"/> 30 minutes <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Discuss patient care with other health care professionals <input type="checkbox"/> Review new information such as labs, wounds <input type="checkbox"/> Modify care plan <input type="checkbox"/> Change prescriptions, other therapy orders <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Document in patient chart.	<input type="checkbox"/> 5 minutes <input type="checkbox"/> 10 minutes <input type="checkbox"/> 15 minutes <input type="checkbox"/> 20 minutes <input type="checkbox"/> 25 minutes <input type="checkbox"/> 30 minutes <input type="checkbox"/> Other: _____
	<input type="checkbox"/> Discuss patient care with other health care professionals <input type="checkbox"/> Review new information such as labs, wounds <input type="checkbox"/> Modify care plan <input type="checkbox"/> Change prescriptions, other therapy orders <input type="checkbox"/> Other:  <input checked="" type="checkbox"/> Document in patient chart.	<input type="checkbox"/> 5 minutes <input type="checkbox"/> 10 minutes <input type="checkbox"/> 15 minutes <input type="checkbox"/> 20 minutes <input type="checkbox"/> 25 minutes <input type="checkbox"/> 30 minutes <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>G0181</b> Total time for month: _____ Must be at least 30 minutes to bill.		

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_