DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

UPDATED PLAN OF PROGRESS FOR OUTPATIENT REHABILITATION

(Complete for Interim to Discharge Claims. Photocopy of CMS-700 or 701 is required.)

1. PATIENT'S LAST NAME	FIRST NAME	M.I.	2. PROVIDER NO.	3. HICN

4. PROVIDER NAME	5. MEDICAL RECORD NO. *(Optional)*	6. ONSET DATE	7. SOC. DATE

8. TYPE	9. PRIMARY DIAGNOSIS *(Pertinent Medical D.X.)*	10. TREATMENT DIAGNOSIS	11. VISITS FROM SOC.
☐ PT ☐ OT ☐ SLP ☐ CR ☐ RT ☐ PS ☐ SN ☐ SW	12. FREQ/DURATION *(e.g., 3/Wk. x 4 Wk.)*		

13. CURRENT PLAN UPDATE, FUNCTIONAL GOALS *(Specify changes to goals and plan.)*

GOALS *(Short Term)* OUTCOME *(Long Term)*	PLAN

I HAVE REVIEWED THIS PLAN OF TREATMENT AND RECERTIFY A CONTINUING NEED FOR SERVICES. ☐ N/A ☐ DC	14. RECERTIFICATION FROM THROUGH N/A

15. PHYSICIAN'S SIGNATURE	16. DATE	17. ON FILE *(Print/type physician's name)* ☐

18. REASON(S) FOR CONTINUING TREATMENT THIS BILLING PERIOD *(Clarify goals and necessity for continued skilled care.)*

19. SIGNATURE *(or name of professional, including prof. designation)*	20. DATE	21. ☐ CONTINUE SERVICES **OR** ☐ DC SERVICES

22. FUNCTIONAL LEVEL *(At end of billing period — Relate your documentation to functional outcomes and list problems still present.)*

22. SERVICE DATES FROM THROUGH

Form CMS-701(11-91)

INSTRUCTIONS FOR COMPLETION OF FORM CMS-701

(Enter dates as 6 digits, month, day, year)

1. **Patient's Name** - Enter the patient's last name, first name and middle initial as shown on the health insurance Medicare card.

2. **Provider Number** - Enter the number issued by Medicare to the billing provider *(i.e., 00–7000).*

3. **HICN** - Enter the patient's health insurance number as shown on the health insurance Medicare card, certification award, utilization notice, temporary eligibility notice, or as reported by SSO.

4. **Provider Name** - Enter the name of the Medicare billing provider.

5. **Medical Record No.** - *(optional)* Enter the patient's medical/ clinical record number used by the billing provider. *(This is an item which you may enter for your own records.)*

6. **Onset Date** - Enter the date of onset for the patient's primary medical diagnosis, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact date is not known enter 01 for the day *(i.e., 120191)*. The date matches occurrence code 11 on the UB-92.

7. **SOC *(start of care)* Date** - Enter the date services began at the billing provider (the date of the first Medicare billable visit which **remains the same on subsequent claims** until discharge or denial corresponds to occurrence code 35 for PT, 44 for OT, 45 for SLP and 46 for CR on the UB-92).

8. **Type** - Check the type therapy billed; i.e., physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), cardiac rehabilitation (CR), respiratory therapy (RT), psychological services (PS), skilled nursing services (SN), or social services (SW).

9. **Primary Diagnosis** - Enter the pertinent written medical diagnosis resulting in the therapy disorder and relating to 50% or more of effort in the plan of treatment.

10. **Treatment Diagnosis** - Enter the written treatment diagnosis for which services are rendered. For example, for PT the primary medical diagnosis might be Degeneration of Cervical Intervertebral Disc while the PT treatment DX might be Frozen R Shoulder or, for SLP, while CVA might be the primary medical DX, the treatment DX might be Aphasia.
If the same as the primary DX enter SAMPLE.

11. **Visits From Start of Care** - Enter the **cumulative total** visits *(sessions)* completed since services were started at the billing provider for the diagnosis treated, through the last visit on this bill. *(Corresponds to UB-92 value code 50 for PT, 51 for OT, 52 for SLP, or 53 for cardiac rehab.)*

12. **Current Frequency/Duration** - Enter the current frequency and duration of your treatment; e.g., 3 times per week for 4 weeks is entered 3/Wk x 4Wk.

13. **Current Plan Update, Functional Goals** - Enter the current plan of treatment goals for the patient for this billing period. *(If the same as shown on the CMS-700 or previous 701 enter "same".)* Enter the short-term goals to reach overall long-term outcome. Justify intensity if appropriate. Estimate time-frames to meet goals, when possible.

14. **Recertification** - Enter the inclusive dates when recertification is required, **even if the ON FILE box is checked in item 17.** Check the N/A box if recertification is not required for the type of service rendered.

15. **Physician's Signature** - If the form CMS-701 is used for recertification, the physician enters his/her signature. If recertification is not required for the type of service rendered, check N/A box**. If the form CMS-701 is not being used for recertification, check the ON FILE box - item 17.** If discharge is ordered, check DC box.

16. **Date** - Enter the date of the physician's signature only if the form is used for recertification.

17. **On File** *(Means certification signature and date)* - Enter the **typed/printed name of the physician** who certified the plan of treatment that is on file at the billing provider. If recertification is not required for the type of service checked in item 8, type/print the name of the physician who referred or ordered the service, **but do not check the ON FILE box.**

18. **Reason(s) For Continuing Treatment This Billing Period** - Enter the **major reasons** why the patient needs to continue skilled rehabilitation **for this billing period** (e.g., briefly state the patient's need for specific functional improvement, skilled training, reduction in complication or improvement in safety and how long you believe this will take, if possible or state your reasons for recommending discontinuance). Complete by the rehab specialist prior to physician's recertification.

19. **Signature** - Enter the signature *(or name)* and the professional designation of the individual justifying or recommending need for care *(or discontinuance)* for this billing period.

20. **Date** - Enter the date of the rehabilitation professional's signature.

21. Check the box if services are continuing or discontinuing at end of this billing period.

22. **Functional Level** *(end of billing period)* - Enter the pertinent progress made through the end of this billing period. Use objective terminology. Compare progress made to that shown on the previous CMS-701, item 22, or the CMS-700, items 20 and 21. Date progress when function can be consistently performed or when meaningful functional improvement is made or when significant regression in function occurs. Your intermediary reviews this progress compared to that on the prior CMS-701 or 700 to determine coverage for this billing period. Send a photocopy of the form covering the previous billing period.

23. **Service Dates** - Enter the From and Through dates which represent this billing period *(should be monthly)*. Match the From and Through dates in field 6 on the UB-92. DO NOT use 00 in the date. Example: 01 08 91 for January 8, 1991.