HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022127

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
9MQ4U97UW70	09/16/2026	09/16/2026 - 11/14/2026	30229	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Richard Mellor 12110 Tullamore Court Unit 206 LUTHERVILLE TIMONIUM, MD 21093	Male	04/20/1946	667-212-1528
	Email: rwmellor@verizon.net		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI: 1487113239		Fax Number: 410-559-3002

Clinical Condition Requiring Homecare:

An 80-year-old male was referred to home health services following a recent hospitalization for elective spinal surgery due to lumbar spinal stenosis and scoliosis. The patient underwent L2-L3 laminectomy and discectomy without complications. Past medical history is significant for hypertension, diabetes mellitus, hyperlipidemia, scoliosis, spinal stenosis, aortic stenosis, and cataracts. The patient resides in a condominium with elevator access and was previously independent with community ambulation without an assistive device, transfers, activities of daily living (ADLs), and instrumental activities of daily living (IADLs). Currently, the patient demonstrates good progress but continues to present with mild deficits in balance, gait, functional transfers, and stair negotiation, with a Tinetti score of 18/28 and a Timed Up and Go (TUG) score of 13.9 seconds. The patient demonstrates good rehabilitation potential and would benefit from continued skilled physical therapy to address balance, gait, transfer, and stair negotiation deficits and to promote a safe return to his prior level of function and independence.<o:p></o:p>

Date of Order<o:p></o:p>
09/16/2026<o:p></o:p>
Physician Face-to-Face Date:
09/11/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: PT-eval & treat dx: Encounter for other orthopedic aftercare<o:p></o:p>
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>

1 - SOC - PT Notes: <o:p></o:p>
Physician: Cook IV, Joseph

Physician Statement on Homebound Status:

Due to diagnosis of Encounter for other orthopedic aftercare, unspecified, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device

ICD-10 CM Principal Diagnosis: Z47.89. Encounter for other orthopedic aftercare

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
M48.061	Spinal stenosis lumbar region without neurogenic claud	JARDIANCE 10 MG / 1 Tablet by mouth ONE TIME DAILY Wait to take this until: September 18, 2026 Generic drug:

M51.16	Intervertebral disc disorders w radiculopathy lumbar region	empagliflozin ACETAMINOPHEN 500 MG Tablet / Take 2 tablets by mouth 4 times daily CARVEDILOL 25 MG / 1 Tablet by mouth TWICE DAILY WITH FOOD GLIMEPIRIDE 4 MG Tablet / Take 2 mg by mouth every morning METFORMIN Take 1000 MG Tablet by mouth daily POTASSIUM 99 MG Capsule / Take 4 capsules by mouth daily PREDNISONE 5 MG Tablet / Take 2.5 mg by mouth daily SIMVASTATIN 20 MG / 1 Tablet by mouth EVERY EVENING for 90 Valsartan: Hydrochlorothiazide - Valsartan: Hydrochlorothiazide 320-12.5 MG / 1 Tablet by mouth EVERY DAY for 90 Amilodipine - Amlodipine Besylate 5mg by mouth twice a day
I10.	Essential (primary) hypertension	
E11.9	Type 2 diabetes mellitus without complications	
E78.5	Hyperlipidemia unspecified	
M35.3	Polymyalgia rheumatica	
I35.0	Nonrheumatic aortic (valve) stenosis	
Z79.84	Long term (current) use of oral hypoglycemic drugs	

Prognosis good	**Mental and Psychosocial Status** COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 1. Rarely, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: No
Functional Limitations Ambulation	**Activities Permitted** Walker, Cane, Up As Tolerated, Transfer bed/Chair, Exercises Prescribed
DME & Supplies rolling walker, grab bars, walker	**Safety Measures** no lifting, no bending, standard precautions, fall precautions, ambulates with assistance
Nutrition diabetic	**Allergies** no known allergies

Advance Directives	Caregiver Status
Full code	2. Non-agency caregiver(s) need training/supportive services to provide assistance
Rehabilitation Potential SELF-CARE: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper., MOBILITY: 3. Independent - Patient completed all the activities by him/herself, with or without an assistive device, with no assistance from a helper.	**DISCHARGE PLAN:** PT: family/caregiver will be responsible for managing treatment
Orders for Discipline and Treatment: 1 - SOC - PT	

PT CAREPLAN

PT frequency WK1: 2 (09/16/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 6. Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months, 7. Currently taking 5 or more medications

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:Full code

09/16/2026 Problems : GG0170J1 - Walk 50 ft with 2 Turns
GG0130F1 - Upper Body Dressing
GG0130A1 - Eating
GG0130H1 - Don/Doff Footwear
GG0130G1 - Lower Body Dressing
GG0130E1 - Shower/Bathe Self
GG0130C1 - Toileting Hygiene
GG0130B1 - Oral Hygiene
GG0170E1 - Chair to Bed to Chair
GG0170P1 - Picking Up Object
GG0170O1 - 12 Steps
GG0170N1 - 4 Steps
GG0170M1 - 1 - Step (curb)
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170K1 - Walk 150 Feet
GG0170I1 - Walk 10 Feet
GG0170G1 - Car Transfer
GG0170F1 - Toilet Transfer
GG0170D1 - Sit to Stand
#1 - Observable Surgical Wound - Posterior Midline - Clean staples intact no drainage staples to be removed by doctor
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
M2020 - Oral Med Management
balance deficit

PT NARRATIVE

80-year-old male referred to Home health services following recent hospital admission for elective spinal surgery secondary to spinal stenosis and scoliosis of lumbar region patient underwent L2 - 3 laminectomy, and dissectomy surgery was uncomplicated past medical history significant for hypertension, diabetes hyperlipidemia. Scoliosis spinal stenosis, aortic stenosis and cataracts. A patient lives in condo elevator access. Plof pt was independent in the community amb no AD, I all transfers, I adls, I iadls. Pt presents with good progress thus far balance tinetti at 18/28, tug 13.9 seconds, minor gait and transfer as well as stair negotiation deficits. Pt has good potential to benefit from skilled physical therapy to address above listed deficits.

PT GOALS

PATIENT-STATED GOAL: To be Independent drive again be able to go on long walks

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Shower/Bathe Self - 05. Setup or clean-up assistance

Car Transfer - 06. Independent

patient/caregiver recalls
* how to achieve wound healing including cleaning and dressing wound
* position changes
* skin care
* diet modification
* record wound measurements
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

Sit to Stand - 06. Independent

Walk 10 Feet - 06. Independent

Walk 50 ft with 2 Turns - 06. Independent

Walk 150 Feet - 06. Independent

Walk 10 ft on Uneven Surface - 06. Independent

1 - Step (curb) - 06. Independent

4 Steps - 06. Independent

12 Steps - 06. Independent

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

Upper Body Dressing - 06. Independent

limited range of motion
limited strength
B0200 - Hearing Deficit
M2102d - Caregiver Performs Treatment
M2102c - Med Admin

PROCEDURES: physician-ordered wound care: #1 - Observable Surgical Wound - Posterior Midline - Clean staples intact no drainage staples to be removed by doctor, Medication management : Review medication with pt and caregiver, cough/deep breathing exercises, incentive spirometer, train caregiver(s) to perform medical/rehabilitation treatments, home exercise program: Seated ankle pumps, knee extension, standing hip flexion, heelraises, hamstring curls, hip abduction, 3x10 use counter for ue support, equipment training, work simplification/energy conservation, gait training on uneven surfaces, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * how to achieve wound healing including cleaning and dressing wound position changes skin care diet modification record wound measurements, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence, Chair to Bed to Chair - 06. Independent, Sit to Stand - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 06. Independent, Walk 50 ft with 2 Turns - 06. Independent, Walk 150 Feet - 06. Independent, Walk 10 ft on Uneven Surface - 06. Independent, 1 - Step (curb) - 06. Independent, 4 Steps - 06. Independent, 12 Steps - 06. Independent, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/16/2026

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. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/11/2026

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.

Certifying Physician or Allowed Practitioner Name and Address **Joseph Cook IV**
6501 Baltimore National Pike
Catonsville, MD 21228
NPI 1124069257

Phone Number 4103682100

Fax Number 16672342991

Physician's Signature and Date Signed

X

Joseph Cook IV, MD
09/11/2026: Date of physician last face-to-face