PALMETTO GBA
A CELERIAN GROUP COMPANY

Home Health Medical Record Audit Form

		Yes	No	N/A
Certification				
Plan of Care				
	Is there a plan of care and certification/re-certification received with the documentation submitted for correct beneficiary?			
	Is the plan of care and certification/re-certification submitted legible? (If a signed copy is not legible, please also include a legible unsigned copy.)			
	Does the plan of care and certification/re-certification submitted cover the dates of service billed on the claim?			
	Is the plan of care and/or certification/re-certification submitted legibly signed and dated by the physician prior to the date the claim was billed to Medicare? Fax stamp dates and Received stamp dates are not accepted as the signature date.			
Face to face				
	Is any required face to face encounter documentation submitted in the medical record.			
	Is the face to face encounter document for the correct beneficiary?			
	Is the face to face encounter document submitted legible, have physician signature and date of encounter?			

	Does the actual encounter visit note address the primary reason home care is being provided and not simply include a diagnosis?			
	Does the face to face encounter occur within 90 days prior to or 30 days after the start of care date?			
	Is the face to face encounter performed by a physician or an allowed non-physician practitioner (NPP) and does the face to face encounter document include a date when the physician or allowed non physician practitioner (NPP) performed the encounter?			
	Is the face to face encounter signed and dated by the certifying physician or allowed non physician practitioner prior to final bill?			
	Is the date the physician or allowed non physician practitioner signed the face to face encounter legible?			
	Does the documentation include the clinical findings that support the patients need for skilled service and homebound status?			
	Does the documentation describe how the patient's clinical findings, as seen during that encounter, support the patients need for skilled services?			
	If the face to face encounter form indicated to see attachment; is the attachment submitted, and labeled as an attachment?			

	Is the additional information submitted to clarify the face to face document signed and dated before the claim was billed to Medicare?			
Nursing services				
Management and evaluation				
	Is the physician narrative for skilled management and evaluation submitted in the medical record?			
	Is the physician narrative for skilled management and evaluation legible and signed by the physician, and dated before the claim was billed to Medicare?			
Skilled Nursing				
	Is the order written on the plan of care sufficient to cover all skilled nursing visits billed or covered by an additional order?			
	Are the physician order(s) signed, dated and legible?			
	Are the physician order(s) dated after the claim was billed to Medicare?			
	Does the physician order(s) include specific discipline(s), frequencies, duration and specific treatments for each discipline?			
	Are the physician order(s) for the PRN visit(s) quantified and qualified?			
	Are the skilled nursing visits for management and evaluation of the patients care plan reasonable and necessary?			
	Is there a physician order, to administer vitamin b12 to include frequency and quantifying diagnosis?			

OASIS				
	Is a copy of the OASIS included in the documentation submitted to support the HIPPS billed?			
Endpoint				
	Is the endpoint statement submitted in the medical record valid and realistic?			
Therapy Services				
Physical therapy				
	Does the order written on the plan of care cover all physical therapy visit(s) billed or are there additional orders?			
	Are the PT orders signed by the physician, dated and legible?			
	Do the PT orders signed by the physician include discipline, frequency and duration?			
	Is the credential of the person who performed the initial physical therapy assessment included?			
	Is the 30 day reassessment visit documented in the medical record?			
	In the initial physical therapy evaluation, are the short term goal(s) and/or long term goal(s) stated in objective, measurable terms, and their expected date of accomplishment as required by the LCD active for the dates of service addressed?			

	Does the plan of treatment include specific functional goals for therapy in objective measurable terms?			
Occupational therapy				
	Does the order written on the plan of care cover all occupational therapy visit(s) billed or are there additional orders?			
	Are the occupational therapy orders signed by the physician, dated and legible?			
	Do the occupational therapy orders signed by the physician include discipline, frequency and duration?			
	Is the credential of the person who performed the initial occupational therapy assessment included?			
	Is the 30 day reassessment visit documented in the medical record?			
	In the initial occupational therapy evaluation, are the short term goal(s) and/or long term goal(s) stated in objective, measurable terms, and their expected date of accomplishment as required by the LCD active for the dates of service addressed?			
	Does the plan of treatment include specific functional goals for therapy in objective measurable terms?			
Speech Language Pathology				

	Does the order written on the plan of care cover all Speech Language Pathology visit(s) billed or are there additional orders?			
	Are the Speech Language Pathology orders signed by the physician, dated and legible?			
	Do the Speech Language Pathology orders signed by the physician include discipline, frequency and duration?			
	Is the credential of the person who performed the initial Speech Language Pathology assessment included?			
	Was the 30 day reassessment visit documented in the medical record?			
	In the initial Speech Language Pathology evaluation, are the short term goal(s) and/or long term goal(s) stated in objective, measurable terms, and their expected date of accomplishment as required by the LCD active for the dates of service addressed?			
	Does the plan of treatment include specific functional goals for therapy in objective measurable terms?			
Dependent Services				
Medical Social Worker				
	Are the Medical Social Worker visit(s) billed Compliant with ordered frequency/duration?			

	Is documentation present to cover medical social worker visit(s)?			
	Does the assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care?			
	Do the service(s) performed by the Medical Social Worker related to obtaining available community resources to assist in resolving the patient's problem?			
Home Health Aide				
	Is documentation present to agree with care plan for each aide visit?			
	Are the home health aide visit(s) reasonable and necessary?			
	Is there documentation of personal care provided by the home health aide or are the aide services an extension of skilled services – such as simple wound care or therapy that has been delegated?			
	Is the sole purpose of the visit to provide housekeeping services only?			
Homebound				

	Is the criteria-one of the homebound requirement met? Criteria-one: the patient must either: because of illness or injury, need for aid or supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave his or her place of residence or have a condition such that leaving his or her home is medically contraindicated? *CMS has stated that checkboxes and use of general terms are not adequate.			
Insulin administration	Is the criteria-two of the homebound requirement met? Criteria-two: there must exist a normal inability to leave home; and leaving home must require a considerable and taxing effort? *CMS has stated that checkboxes, and use of general terms and re-stating the requirement are not adequate.			
	Is there a treatment order to administer daily insulin submitted in the medical record?			
	Is the documentation of why the patient can't self-inject insulin present in the medical record?			
	Is there documentation of why the patient's caregiver can't/won't administer insulin present in the medical record?			
	Are the results of the most recent HBA1C included in the medical record ?			
	Does the plan of care include the order to monitor and report the HBA1C levels quarterly (and			

	no less often than 120 days) or indicate if these are being performed by the physician?			
	Are the HBA1C level results greater than 120 days apart?			
	Is skilled nurse visit(s) reasonable and necessary?			