CLINICAL RECORD REVIEW

Timepoint:
❍ SOC ❍ ROC ❍ Recertification ❍ Follow-up ❍ Discharge ❍ Other_____

Review Date:

CLERICAL

Required forms (signed and dated per policy):

❑ Service Agreement/Consent ❑ Plan of Care (POC)/485 ❑ Advance Directive Information
❑ Medication Profile ❑ OASIS Privacy Statement ❑ Advance Beneficiary Notice ❑ NA
❑ HIPAA Privacy Statement ❑ Medicare Secondary Payer Worksheet ❑ Individualized Emergency Preparedness Plan
❑ Intake/Referral Information ❑ Emergency Contact Person Identified ❑ Other:_____

	Yes	No	Comments	N/A
1. Documentation completed within agency timeframes.	❍	❍		❍
2. Start of care date matches first billable visit date.	❍	❍		❍
3. Consent form is dated on or prior to start of care.	❍	❍		❍
4. Payer source identified correctly on service agreement/consent.	❍	❍		❍
5. Dollar amount owed by patient identified on service agreement/consent.	❍	❍		❍
ASSESSMENT AND PLAN OF CARE				
1. Initial assessment visit was made within 48 hours of referral, or patient's return home, or on the physician's ordered start of care date (M0102, M0104).	❍	❍		❍
2. Homebound status documented in measurable terms that reflect functional status, SOB, pain level, and medical restrictions.	❍	❍		❍
3. OASIS assessment(s) completed within agency timeframe.	❍	❍		❍
4. Primary diagnosis is driving the home health services.	❍	❍		❍
5. Living situation/assistance is correctly reflected in medical record (M1100).	❍	❍		❍
6. Vision deficits (B1000) reflected in most situations; can see medication labels and newsprint. Telephone use as noted in medical record.	❍	❍		❍
7. Pain status (J0510, J0520, J0530, M2310) reflected in notes, medication regime, and demonstrated functional ability.	❍	❍		❍
8. Pain is reevaluated and managed effectively throughout care episode (noted in J1900, M2401).	❍	❍		❍
9. Skin/wound history supports wound type (M1306, M1307, M1311 M1322-M1342). (Skin lesion noted in M2401.)	❍	❍		❍
10. Wounds are measured upon SOC/ROC/DC and _____ (per organizational policy).	❍	❍		❍
11. Shortness of breath response (M1400) reflects primary and secondary diagnosis, general condition, and demonstrated functional debility/ability.	❍	❍		❍
12. Respiratory treatment reflected in shortness of breath (M1400) and O_2 use.	❍	❍		❍
13. Urinary Incontinence assessment (M1610) reflects debility, catheter presence and frequency of incontinence.	❍	❍		❍
14. Neuro/emotional/behavior (M1700-M1720, M1740, M1745) reflects past medical history and assessment findings. Depression as noted in medical record (D0150, M2401).	❍	❍		❍

PATIENT NAME – Last, First, Middle Initial | ID#

ASSESSMENT AND PLAN OF CARE (Cont'd.)	Yes	No	Comments	N/A
15. ADL actions (M1800-M1870, GG0100, GG0130-GG0170) reflect safe and effective cognitive and physical abilities.	❍	❍		❍
16. IADL action reflects safe and effective cognitive and physical abilities (noted in M2102).	❍	❍		❍
17. Therapy threshold (M2200) matches services ordered.	❍	❍		❍
18. Visits provided match POC service orders.	❍	❍		❍
19. Treatments provided match treatment orders.	❍	❍		❍
20. Laboratory results are available in the medical record.	❍	❍		❍
21. HHA Supervisory visits match frequency of orders.	❍	❍		❍
22. Documentation provides evidence of interdisciplinary communication.	❍	❍		❍
MEDICATION REVIEW				
1. High risk drug education is taught to patient/caregiver at SOC including how and when to report problems (M2010).	❍	❍		❍
2. Drug education intervention is taught and/or reinforced during certification period as needed to patient/caregiver throughout certification period (M2020, M2030).	❍	❍		❍
3. Clinically significant medication issues reported to the physician or physician-designee within one calendar day of assessment to resolve the issue including reconciliation (M2003, M2005).	❍	❍		❍
4. SN provides medication review for therapy only cases.	❍	❍		❍
5. Medication profile correlates with physician orders.	❍	❍		❍
6. Drug regimen review is complete for the medication profile (M2001).	❍	❍		❍
7. Medications are associated with conditions in the diagnosis list.	❍	❍		❍
ACUTE CARE HOSPITALIZATION				
1. Home evaluated for environmental hazards at SOC.	❍	❍		❍
2. Patient's caregiver or support system(s) identified (noted in M2102).	❍	❍		❍
3. Multifactor fall risk assessment completed at SOC (e.g., MAHC-10 or TUG).	❍	❍		❍
4. Action/emergency plan provided for patient/caregiver (e.g. disease symptoms exacerbates or issues arise).	❍	❍		❍
5. Agency contact names and numbers provided to patient/ caregiver at SOC.	❍	❍		❍
6. Reportable signs/symptoms are provided to patient/ caregiver at SOC.	❍	❍		❍
7. Patient's ability to obtain supplies and/or medications evaluated at SOC.	❍	❍		❍
8. Referrals made when necessary (M2401(c)).	❍	❍		❍
9. Care plan update provided to all members of the interdisciplinary team.	❍	❍		❍

COMMENTS

Auditor's Signature/Title:	Date:
PATIENT NAME – Last, First, Middle Initial	ID#