PRE-BILLING AUDIT

Agency Office:_____ **Date:**_____

Patient MR:_____ **Payment Period:**_____

		YES	NO	N/A	COMMENTS
1. Last OASIS _____ M0090 date_____		❍	❍	❍	
2. Unique Tracking Number (UTN) required for pre-claim review		❍	❍	❍	If yes, UTN:_____
3. OASIS used for functional score transmitted and accepted		❍	❍	❍	
4. NOA submitted and accepted date _____		❍	❍	❍	
5. Frequency	**SN correct**	❍	❍	❍	
	PT/PTA correct	❍	❍	❍	
	30-day evaluation complete	❍	❍	❍	
	OT/OTA correct	❍	❍	❍	
	30-day evaluation complete	❍	❍	❍	
	SLP correct	❍	❍	❍	
	30-day evaluation complete	❍	❍	❍	
	MSW correct	❍	❍	❍	
	HHA correct	❍	❍	❍	
	❑ Action: Verbal order needed	❍	❍	❍	Sent:_____ Sent:_____ Sent:_____
	❑ Missed visit note needed	❍	❍	❍	Sent:_____ Sent:_____ Sent:_____
6. All orders followed: i.e., wound care as ordered		❍	❍	❍	
7. All orders signed *(all must be signed and dated by Physician/NPP*)*					
	Plan of Care	❍	❍	❍	
	Number of verbal orders for payment period _____	❍	❍	❍	
	Number of verbal orders signed _____	❍	❍	❍	
8. All diagnosis codes documented/verified with Physician/NPP*, i.e., referral, history and physical, communication notes, orders, any changes in the diagnosis from Billing Period 1 to Billing Period 2.		❍	❍	❍	
9. All diagnosis codes as specific as possible based on info provided by the Physician/NPP*		❍	❍	❍	

PRE-BILLING AUDIT

		YES	NO	N/A	COMMENTS
10. All verified dx codes communicated to biller for inclusion on final claim		❍	❍	❍	
11. If SOC, Face-to-Face documentation includes the following documents:		❍	❍	❍	
	Physician/NPP* signature and date within allowed timeframe	❍	❍	❍	
	Homebound description	❍	❍	❍	
	Home Health Services	❍	❍	❍	
	Primary Reason for Care "matching primary diagnosis"	❍	❍	❍	List:
	Supplemental documentation as needed	❍	❍	❍	
	Date of Face-to-Face on certification before date POC signed	❍	❍	❍	
12. Occurrence code applies		❍ 61	❍ 62	❍	

**According to federal law, nurse practitioners or physician assistants may sign the POC, certification, and interim orders without co-signature. Check your state law for restrictions.*

NOTES

Completed by:_____

Hold for - See above and:

Released for billing **Date:**_____ **Initials:**_____