Home Health Medical Records Audit Form

Auditor's Name/Title:

Date_____

.	Yes	No	N/A	MR#	Comments
Admission					
1. Patient referral sheet complete					
2. Pre-Admit Physician Order, signed, dated or VO signed by RN + Physician					
3. Primary DX M1020					
SecondarM1022					
M1022					
M1022					
M1022					
M1022					
M1022					
All DX supported and sequenced properly					
4. Medication (N)ew and (C) hanged Interactions, iincluded food/OTC					
5. Admission consistent with agency admission policies					
6. Patient Client/Service Agreement, signed, dated, and complete					
7. Insurance Screening Form, signed and complete					
8. Medical Necessity noted					
9. Acknowledgement, receipt, and explanation of the items below: **a**. Home Care Patient Rights and Responsibilities **b.** Privacy Act Statement-Health Care Records **c.** Complaint Procedure **d.** Authorization for Use or Disclosure of Health Information (if applicable). **e.** Statement of Patient Privacy Rights (OASIS) **f.** Consent for Collection and Use of Information (OASIS). **g.** Emergency Preparedness Plan/Safety Instructions **h.** Advance Directives and HHABN					
10. Complete Post Evaluation/ D/C Summary Report by RN/ PT/OT/ST on: a. Start of Care b. Resumption of Care c. Recertification					
Plan of Care (485)					

11. Plan of Care signed and dated by physician within 30 working days or state specific ___ days					
12. Diagnoses consistent with care ordered					
13. Orders current					
14. Focus of care substantiated					
15. Daily skilled nurse visit frequencies w/ indication of end point					
16. Measurable goals for each discipline					
17. Tinetti or TUG completed at SOC					
16. Recertification plan of care signed and dated within 30 days					
17. BiD Insulin visits documented with vision, musculoskeletal need, not willing / capable caregiver. MSW q episode					
18. SN consult					
Medication Profile Sheet					
19. Medication Profile consistent with the 485					
20. Medication Profile updated at Recertification, ROC, SCIC, initialed and dated					
21. Medication Profile complete with Pharmacy information					
Physician Orders/Change Verbal Orders					
22. Change/verbal orders include disciplines, goals, frequencies, reason for change, additional supplies as appropriate					
23. Change orders signed and dated by physician within 30 working days					
OASIS Assessment Form					
24. Complete, signed, and dated by: ☐ RN ☐ PT ☐ ST ☐ OT					
25. M2200 answer meets the threshold for a Medicare high casemix group					
26. M1020 & M1022 Diagnoses and ICD 9 are consistent with the Plan of Care					
27. All OASIS assessments were exported within 30 days					
28. OASIS Recertifications were done within 5 days of the end of the episode					
29. All OASIS were reviewed for consistency in coordination with the discipline who completed the form					
Skilled Nursing Clinical Notes					
30. Visit frequencies and duration consistent with Physician Orders					
31. Orders written for visit frequencies/treatment change					

32. Homebound status supported on each visit note					
33. Measurable goals for each discipline with specific time frames					
34. Frequency of visits appropriate for patient's needs and interventions provided					
35. Appropriate missed visit (MV) notes					
36. Skilled care evident on each note					
37. Evidence of coordination of care					
38. Every note signed and dated					
39. Follows the Plan of Care (485)					
40. Weekly wound reports are completed					
41. Missed visit reports are completed					
42. Pain assessment done every visit with intervention (if applicable)					
43. Abnormal vital signs reported to physician and Case Managers					
44. Evidence of interventions with abnormal parameters/findings					
45. Skilled Nurse Discharge Summary/Instructions completed					
46. LVN supervisory visit every 30 days by Registered Nurse					
Certified Home Health Aide					
47. Visit frequencies and duration consistent with physician orders					
48. Personal care instructions documented, signed & dated					
49. Personal care instructions modified as appropriate					
50. Notes consistent with personal care instructions noted on the CHHA assignment sheet completed by the RN/PT/ST/OT					
51. Notes reflect supervisor notification of patient complications or changes					
52. Visit frequencies appropriate for patient needs					
53. Each note reflects personal care given					
54. Supervisory visits at least every 14 days by RN or PT					
55. Every note signed and dated					
PT					
56. Assessment includes evaluation, careplan, and visit note					
57. Evaluation done within 48 hours of referral physician order or date ordered					
58. Visit frequencies/duration consistent with physician orders					

59. Evidence of need for therapy/social service					
60. Appropriate Missed Visit (MV) notes					
61. Notes consistent with physician orders					
62. Evidence of skilled service(s) provided in each note					
63. Treatment/services provided consistent with physician orders and care plan					
64. Notes reflect supervisor and physician notification of patient complications or changes					
65. Specific Eval & "TREAT" orders					
66. Verbal Orders for "TREAT" orders prior to care					
67. Homebound status validated in each visit note					
68. Notes reflect progress towards goals					
69. Evidence of discharge planning					
70. Evidence of therapy home exercise program					
71. Discharge/transfer summary complete with goals met/unmet					
72. Supervision of PTA/OTA at least every two weeks					
73. Every visit note signed and dated					
SLP					
74. Assessment includes evaluation, careplan, and visit note					
75. Evaluation done within 48 hours of referral physician order or date ordered					
76. Visit frequencies/duration consistent with physician orders					
77. Evidence of need for therapy/social service					
78. Appropriate Missed Visit (MV) notes					
79. Notes consistent with physician orders					
80. Evidence of skilled service(s) provided in each note					
81. Treatment/services provided consistent with physician orders and care plan					
82. Notes reflect supervisor and physician notification of patient complications or changes					
83. Homebound status validated in each visit note					
84. Notes reflect progress towards goals					
85. Evidence of discharge planning					

86. Evidence of therapy home exercise program					
87. Discharge/transfer summary complete with goals met/unmet					
88. Supervision of PTA/OTA at least every two weeks					
89. Every visit note signed and dated					
Miscellaneous					
90. Progress Summary completed (30-45 days) each episode signed and dated					
91. Field notes are submitted and complete					
92. Chart in chronological order					
93. Chart in order per agency policy					
94. Patient name and medical recrods number on every page					
95. Physician orders are completed/updated for clinical tests such as: a. Coumadin: Protime/INR b. Hemoglobin A1C c. CBC, Metabolic Panel, CMP d. Others:					
96. Communication with physician regarding test results					

Additional Comments/Recommendations

THE FOLLOWING IS APPLICABLE FOR QUARTERLY MEDICAL REVIEW REPORT
REVIEWED AND SIGNED BY THE FOLLOWING DISCIPLINARY REPRESENTATIVE

Registered Nurse

Occupational Therapist (if applicable)

Physical Therapist (if applicable)

Speech Language Pathologist (if applicable)

Medical Director

MSW (if applicable)