Home Health Medical Records Audit Form **(Updated for CY2013)**

Auditor's Name/Title: _____

Date: _____

	Yes	No	N/A	MR #	Comments
Admission					
1. Patient Referral Sheet Complete					
Timely Initiation of Care					
Face to Face Encounter Within 90 Days To SOC					
Face to Face Encounter Within 30 Days To SOC					
History of Physical Present					
2. Pre-Admit Physician Order – Signed, Dated or VO signed by RN + Physician					
3. Primary DX M1020					
Secondary M1022					
M1022					
M1022					
M1022					
M1022					
M1022					
Any Codes 401.1					
Any Codes 401.9					
All DX Supported & Sequenced Properly					
4. Medication (N)ew and (C)hanged					
Interactions – Included Food/OTC					
5. Admission consistent with Agency Admission Policies					
6. Patient/Client Service Agreement – Signed, Dated & Complete					
7. Insurance Screening Form – Signed & Complete					
8. Medical Necessity Noted					
9. Acknowledgement, Receipt & Explanation of the Items Below: a. Home Care Patient Rights & Responsibilities					
b. Privacy Act Statement-Health Care 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 & Use of Information (OASIS)					

	Yes	No	N/A	MR #	Comments
g. Emergency Preparedness Plan/Safety Instructions					
h. Advance Directives & 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 & 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 with Indication of End Point					
16. Measurable Goals for Each Discipline					
17. Tinetti or TUG Completed at SOC					
18. Recertification Plan of Care Signed & Dated Within 30 Days or State Required Time					
19. BiD Insulin Visits Documented with Vision, Musculoskeletal Need, Not Willing/Capable Caregiver. MSW Every Episode					
20. Skilled Nurse Consult					
Medication Profile Sheet					
21. Medication Profile Consistent with the 4 485					
22. Medication Profile Updated at Recertification, ROC, SCIC, Initialed & Dated					
23. Medication Profile Complete with Pharmacy Information					
Physician Orders/Change Verbal Orders					
24. Change/Verbal Orders Include Disciplines, Goals, Frequencies, Reason for Change, Additional Supplies as Appropriate					
25. Change Orders Signed & Dated by Physician Within 30 Working Days					
OASIS Assessment Form					
26. Complete, Signed & Dated by: _____					
27. M2200 Answer Meets the Threshold for a Medicare High Case Mix Group					
28. M1020 & M1022 Diagnoses & ICD-9 are Consistent with the Plan of Care					

	Yes	No	N/A	MR #	Comments
29. All OASIS Assessments Were Exported Within 30 Days					
30. OASIS Recertifications Were Done Within 5 Days of the End of the Episode					
31. All OASIS Were Reviewed for Consistency in Coordination with the Discipline Who Completed the Form					
Skilled Nursing Clinical Notes					
32. Visit Frequencies & Duration are Consistent with Physician Orders					
33. Orders Written for Visit Frequencies/ Treatment Change					
34. Homebound Status Supported on Each Visit Note					
35. Measurable Goals for Each Discipline with Specific Time Frames					
36. Frequency of Visits Appropriate for Patient's Needs & Interventions Provided					
37. Appropriate Missed Visit (MV) Notes					
38. Skilled Care Evident on Each Note					
39. Evidence of Coordination of Care					
40. Every Note Signed & Dated					
41. Follows the Plan of Care (485)					
42. Weekly Wound Reports are Completed					
43. Missed Visit Reports are Completed					
44. Pain Assessment Done Every Visit with Intervention (If Applicable)					
45. Abnormal Vital Signs Reported to Physician & Case Managers					
46. Evidence of Interventions with Abnormal Parameters/Findings					
47. Skilled Nurse Discharge Summary/ Instructions Completed					
48. LVN Supervisory Visit Every 30 Days by Registered Nurse					
Certified Home Health Aide					
49. Visit Frequencies & Duration Consistent with Physician Orders					
50. Personal Care Instructions Documented, Signed & Dated					
51. Personal Care Instructions Modified as Appropriate					
52. Notes Consistent with Personal Care Instructions Noted on the CHHA Assignment Sheet Completed by the RN/PT/ST/OT					
53. Notes Reflect Supervisor Notification of Patient Complications or Changes					
54. Visit Frequencies Appropriate for Patient Needs					

	Yes	No	N/A	MR #	Comments
55. Each Note Reflects Personal Care Given					
56. Supervisory Visits at Least Every 14 Days by RN or PT					
57. Every Note Signed & Dated					
PT					
58. Assessment Includes Evaluation, Care Plan & Visit Note					
59. Evaluation Done Within 48 Hours of Referral Physician Order or Date Ordered					
60. Visit Frequencies/Duration Consistent with Physician Orders					
61. Evidence of Need for Therapy/Social Service					
62. Appropriate Missed Visit (MV) Notes					
63. Notes Consistent with Physician Orders					
64. Evidence of Skilled Service(s) Provided in Each Note					
65. Treatment/Services Provided Consistent with Physician Orders & Care Plan					
66. Notes Reflect Supervisor & Physician Notification of Patient Complications or Changes					
67. Specific Evaluation & "TREAT" Orders Prior to Care					
68. Verbal Orders for "TREAT" Orders Prior to Care					
69. Homebound Status Validated in Each Visit Note					
70. Notes Reflect Progress Toward Goals					
71. Evidence of Discharge Planning					
72. Evidence of Therapy Home Exercise Program					
73. Discharge/Transfer Summary Complete with Goals Met/Unmet					
74. Assessment & Evaluation performed by Qualified Therapist Every 30 Days					
75. Supervision of PTA/OTA at Least Every 2 Weeks					
76. Qualified Therapy Visit 13th Visit (11, 12, 13)					
77. Qualified Therapy Visit 19th Visit (17, 18, 19)					
78. Every Visit Note Signed & Dated					
SLP					
79. Assessment Includes Evaluation, Care Plan & Visit Note					
80. Evaluation Done Within 48 Hours of Referral Physician Order or Date Ordered					
81. Visit Frequencies/Duration Consistent with Physician Orders					

	Yes	No	N/A	MR #	Comments
82. Evidence of Need for Therapy/Social Service					
83. Appropriate Missed Visit (MV) Note					
84. Notes Consistent with Physician Orders					
85. Evidence of Skilled Service(s) Provided in Each Note					
86. Treatment/Services Provided Consistent with Physician Orders & Care Plan					
87. Notes Reflect Supervisor & Physician Notification of Patient Complications or Changes					
88. Homebound Status Validated in Each Visit Note					
89. Notes Reflect Progress Toward Goals					
90. Evidence of Discharge Planning					
91. Evidence of Therapy Home Exercise Program					
92. Discharge/Transfer Summary Complete with Goals Met/Unmet					
93. Supervision of PTA/OTA at Least Every 2 Weeks					
94. Every Visit Note Signed & Dated					
Miscellaneous					
95. Progress Summary Completed(30-45Days) Each Episode Signed & Dated					
96. Field Notes are Submitted & Complete					
97. Chart in Chronological Order					
98. Chart in Order per Agency Policy					
99. Patient Name & Medical Records Number on Every Page					
100. Physician Orders are Completed/ Updated for Clinical Tests Such as:					
a. Coumadin: Protime/INR					
b. Hemoglobin A1C					
c. CBC, Metabolic Panel, CMP					
d. Others: _____					
101. Communication with Physician Regarding Test Results					
Process Measures:					
Timely Initiation of Care					
Influenza Received					
PPV Ever Received					
Heart Failure					
DM Foot Care & Education					
Pain Assessment					
Pain Intervention					
Depression Assessment					
Medication Education					
Falls Risk Assessment					
Pressure Ulcer Prevention					
Pressure Ulcer Risk Assessment					

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)*

MR # _____