HOME HEALTH
DOCUMENTATION CHECKLIST TOOL

Face-to-Face Clinical Documentation	
Is a Face-to-Face Encounter note present? • **Actual clinical or progress note or discharge summary**	☐
Was the Face-to-Face Encounter note performed, signed and dated by an allowed provider type?	☐
Does the Face-to-Face Encounter note indicate the reason for the encounter and was this assessment related to the need for home health services (encounter is related to the primary reason for home care)?	☐
Is the Face-to-Face Encounter note dated between 90 days before or 30 days after the start of home health services?	☐
Is HHA documentation incorporated into the certifying physician's or allowed practitioner's medical record? Please note any incorporation of documentation must be corroborated by the submitted clinical/medical documentation (when supporting homebound criteria and/or skilled service need for the referral to homecare).	☐

Homebound Requirement			
Criteria One		**Criteria Two**	
The patient must either because of illness or injury need: • Mobility assist device or • Special transportation or • Assistance of another person to leave the home or • Has a condition that leaving home is medically contraindicated	☐	If the patient meets one of criterion one, they must also meet both criterion below: • The patient has a normal inability to leave the home **AND** • Requires a considerable and taxing effort to leave the home	☐
Does the patient meet Criteria One and Criteria Two?			☐

Plan of Care			
Does the Plan of Care contain:			☐
• All pertinent diagnoses • Patient's mental, psychosocial, and cognitive status • Types of services, supplies, and equipment required • Frequency and duration of visits to be made • Prognosis • Rehabilitation potential • Functional limitations • Activities permitted	• Nutritional requirements • All medications and treatments • Safety measures to protect against injury • Description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors	• Patient and caregiver education and training to facilitate timely discharge • Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient • Information related to advanced directives; and • Any additional items the HHA, physician, or allowed practitioner chooses to include	

Plan of Care	
Does the Plan of Care include therapy services? If yes, the course of therapy treatment must be established by the physician or allowed practitioner after any needed consultation with the qualified therapist. Does the Plan of Care address: • Measurable therapy treatment goals • Frequency and duration of therapy services • Specific procedures and modalities	☐
Does the plan of care contain a signed and dated verbal start of care date?	☐
Is the plan of care signed and dated by the physician or allowed practitioner prior to billing?	☐
If using electronic signatures, are they verifiable to the reviewer (e.g. signed by, verified by, and/or with date/time stamps, or as stated in the agency electronic signature policy). If using electronic signatures please include the agency electronic signature policy.	☐

Orders	
Is there an order for each visit provided?	☐
Are all orders signed and dated by the physician or allowed practitioner prior to billing? If applicable, do the orders contain a timely verbal start of care?	☐

Reasonable and Medically Necessary Skilled Services Provided by HHA	
Are the skilled service and the reason the skilled service is necessary for the beneficiary documented in objective terms?	☐
Is a caregiver providing a service that adequately meets the beneficiary's needs?	☐

Certification/Recertification (usually found on the start of care 485/plan of care)	
Example Certification Statement: *I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with a physician or an allowed non-physician practitioner on 11/01/2020 and the encounter was related to the primary reason for home health care.*	
Did the physician or allowed practitioner certify (attest) that: • The patient is homebound • The patient requires skilled care • A plan of care has been established and is periodically reviewed by a physician or allowed practitioner • The patient is under the care of a physician or allowed practitioner • The patient had a face-to-face encounter and the certifying physician or allowed practitioner documented the date of the encounter	☐
Did the same physician or allowed practitioner certify/attest to all five elements above?	☐

Recertification	
Is the Physician or Allowed Practitioner Recertification statement present and signed and dated prior to billing? **Note:** Include the initial plan of care/certification/485 for the start of care episode.	☐

OASIS	
Is there an accepted matching OASIS submission in iQIES?	☐
Do the following data elements match the claim and OASIS assessment: • Home health agency (HHA) Certification Number (OASIS item M0010) • Beneficiary Medicare Number (OASIS item M0063) • Assessment Completion Date (OASIS item M0090) • Reason for Assessment (OASIS item M0100) equal to 01, 03, or 04	☐

RESOURCES:

- Medicare Benefit Policy Manual (CMS Pub. 100-02, Ch. 7) - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf
- Medicare Program Integrity Manual (CMS Pub. 100-08, Ch. 6) - https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf