Reviewing a Home Health Chart for Quality

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Session Type:  Educational Sessions
Session Level:  Intermediate

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Combined Sections Meeting
February 3-6, 2014
Las Vegas, Nevada
Arlynn Hansell has been a Physical Therapist in the home health setting since October 1998, holding positions of field therapist, rehab manager, and quality/compliance assurance. As owner of Therapy and More, LLC, the focus of the business is on auditing therapy documentation and practice in order to better position agencies against audit risk. Consulting services further consist of OASIS auditing and coding practice.

Arlynn has been a member of the American Physical Therapy Association since 1995, where she is a member of the Practice Committee for the Home Health Section.

She is a member of the Home Health Advisory Board for the Board of Medical Specialty Coding (BMSC), where she serves as Secretary. Responsibilities include assisting in the development of the ICD-9-CM and ICD-10-CM coding exams and OASIS exam for DecisionHealth. She is the author of the DecisionHealth online course: ICD-10 Specialty Training: Therapy.

Arlynn has written numerous articles for various home health publications, and has presented at workshops in Las Vegas, the Utah State Association HH conference, DecisionHealth's Coding Summit and Outcomes & OASIS seminars.
Agenda

- Welcome, Introductions & Course Overview
- Overview of the audit types
- Introduction to review styles and focus
- Wrap Up and Q & A

Objectives:
Upon completion of this course, the attendee will be able to:
1. Relate the government entity (ZPIC, RAC, etc.) to the corresponding audit focus.
2. Design an outline for a thorough audit document for use in their agency.
3. Review a chart for thoroughness and correctness of documentation.
Audit Types

For the sake of clarity in this presentation:

- AUDITS will be referred to as those things that are done to an agency by an outside source

- REVIEWS will be referred to as those things we do internally to try to safeguard against the audits
Audit Types

- There are many audit types currently in play in the Medicare governmental review market, commonly known as “alphabet soup”.
  - CERT
  - ZPIC
  - MRA (known as RAC)
  - MAC
CERT

Comprehensive Error Rate Testing – What it does

- Measures the paid claims error rate for MCR claims submitted to MACs (Medicare Administrative Contractors).
- Ensures claim is paid correctly
- Random selection of claims; request medical records from providers that billed for service
CERT is looking at….

- Payments that should not have been made or payments made in an incorrect amount (including overpayments & underpayments)
- Payment to an ineligible recipient
- Payment for an ineligible service
- Any duplicate payment
- Payment for services not received
- Payment for an incorrect amount

It’s all about the money….  

Three conditions of payment:
1. All procedures, diagnoses, and modifiers submitted on a claim should be supported by information in the medical record
2. The medical need for services must be included in the medical record
3. The legible signature of the person that performed the service is required.
Common detected errors

Most frequent CERT errors per quarterly reports:
- Insufficient documentation
  - Unable to determine if some of the services allowed were actually provided
  - Adequate documentation was not present so that an informed decision could be made as to whether or not the services were medically necessary
- Medically unnecessary services
- Incorrect coding
Medicare Administrative Contractors

• Uniform administrative entity processing MCR Part A and B
• Serve as the primary operational contact between the MCR Fee-For-Service program and the health care providers
• Seven program integrity zones created based on MAC jurisdictions
  • Thus the creation of the Zone Program Integrity Contractors

Medicare Recovery Auditors (RAC)
Medicare Recovery Auditor $uccess

• Original demonstration program (ran from 2005-2008):
  • Recouped nearly $ 1 Billion
  • Returned ~ $ 38 Million in underpayments
    • HUGE net gain = favorite program

• MRA agency incentive?
  • Are paid a contingency fee based on amount of collected repayments
    • Made $ 187.2 Million in demonstration program

• So what happened? It became a permanent program in 2010 under the Tax Relief and Health Care Act of 2006

MRA Nationwide Progress 3rd QTR 2013
*Dollars in Millions

<table>
<thead>
<tr>
<th></th>
<th>OVERPAYMENTS COLLECTED</th>
<th>UNDERPAYMENTS RETURNED</th>
<th>TOTAL QUARTER CORRECTIONS</th>
<th>FY TO DATE CORRECTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide Totals</td>
<td>$855.3</td>
<td>$36.3</td>
<td>$891.6</td>
<td>$2,339.3</td>
</tr>
</tbody>
</table>

And they haven’t really started in on home care yet!
MRA Claims Review

Recovery Auditors are required to employ a staff consisting of nurses, therapists, certified coders and a physician

What they look for:
1. Improper payments under MCR Parts A and B for services that were not medically necessary
2. Improper payments for services where the documentation does not support the claim.
3. Incorrect billing (incorrect coding, duplicate services)
4. Payments made involving other errors (including overpayment/underpayments)

MRA review plans must be posted on its website prior to the widespread review per the CMS approval process.

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MRA Review

• Limited to a three-year look-back period from the date the claim was paid

• What they are not permitted to review:
  • Claims reviewed by another MCR contractor
  • Claims involved in a potential fraud investigation
  • Claims involved in MCR demonstration programs
MRA Review Process

• Three types of review:
  • Automated (no medical record needed)
  • Semi-Automated (claims review using data and potential human review of a medical record or other documentation)
  • Complex (medical record required)

ZPIC
Zone Program Integrity Contractors

- Identify improper billing patterns that indicate potential fraud, waste, and abuse
- Investigate cases of suspected fraud
- Identify need for administrative actions such as payment suspensions and prepayment edits
- Refer cases to OIG (Office of Inspector General) for further investigation and initiation of civil or criminal prosecution

Differences between ZPIC and MRA

<table>
<thead>
<tr>
<th>ZPIC</th>
<th>MRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Identify potential fraud, waste, and abuse</td>
<td>- Identify overpayments</td>
</tr>
<tr>
<td>- Conduct audits of all claims (pre- and post- pay audits)</td>
<td>- Conduct post-pay audits</td>
</tr>
<tr>
<td>- Purposefully selects providers to audit</td>
<td>- Randomly audits providers</td>
</tr>
<tr>
<td>- May show up at your agency</td>
<td>- Requests records</td>
</tr>
</tbody>
</table>
Medicare Fraud examples

- Incorrect reporting of diagnoses to maximize payments: "UPCODING"
- Participation in anti-kickback schemes
- Misrepresentations of dates and services provided

ZPIC is like the gatekeeper...

- They don’t collect monies, but they will tell on you to the MACs, who in turn issue demand letters to recoup overpayments
- They won’t arrest you, but they will refer your case to the OIG or Office of Investigations
Audit/Review Focus

Five Elements Critical to the Claim

- Comprehensive Assessment
- Diagnosis Codes
- POC/485
- Documentation
- Physician Orders
Chart Reviews

- There are many different directions a chart review can go in
- Must define up front what the objective of the review is in order to correctly and efficiently detect any problems
  - Documentation quality
  - OASIS compliance
  - Coding compliance
  - CMS compliance (CoP, etc.)
  - Documentation compliance

Sample SOC Audit Tool

A typical agency-designed review tool is usually geared toward *compliance* with the CoPs – are we hitting the time points, are we doing what we are supposed to be doing, when we are supposed to be doing it. There is typically a Yes/No/NA scoring system to it. The “funny” part is, when it comes to therapy, there is usually one or two lines to the effect of, “Documentation supports skilled need”. Soooo…. 
<table>
<thead>
<tr>
<th>Therapy</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is this a single therapy case?</td>
<td></td>
<td></td>
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<tr>
<td>2. Is this a multiple therapy case?</td>
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<tr>
<td>3. Is the therapy reassessment(s) completed for the 13th visit timeframe?</td>
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<tr>
<td>4. If no, which therapy service missed? PT_____ OT_____ ST_____</td>
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<tr>
<td>5. If late: Was the late reassessment completed?</td>
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<td></td>
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<tr>
<td>6. Is the therapy reassessment(s) completed for the 19th visit timeframe?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7. If no, which therapy service missed? PT_____ OT_____ ST_____</td>
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<tr>
<td>8. If late: Was the late reassessment completed?</td>
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<tr>
<td>9. Is there a re-evaluation completed by the PT by day 30?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>10. Is there a re-evaluation completed by the OT by day 30?</td>
<td></td>
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<td></td>
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<tr>
<td>11. Is there a re-evaluation completed by the ST by day 30?</td>
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<tr>
<td>12. Is a standardized tool used for each initial assessment/reassessment/re-evaluation/discharge for PT?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Is a standardized tool used for each initial assessment/reassessment/re-evaluation/discharge for OT?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Is a standardized tool used for each initial assessment/reassessment/re-evaluation/discharge for ST?</td>
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<tr>
<td>15. Does the PT documentation support progress towards goals? (Improved strength, improved ambulation, improvement in special or standard tests, improved function or a decreased need for assistance)</td>
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</tbody>
</table>

**Taking a different kind of look**
This is not your momma’s compliance review!

• Mission: what the course title said. How to review a chart for quality.

Focus…Documentation Quality

• What is the definition of a “quality record”?
  • A document recording specific information that relates to a procedure or work instruction. Quality records are proof that an organization is complying with its procedures and policies.
Quality Record

So, to break that down into what a quality review will seek out:

A document recording specific information that relates to a procedure or work instruction:

➢ does the visit documentation support the orders

Quality records are proof that an organization is complying with its procedures and policies:

➢ therapists are using tests and measures; functional reporting; evidence-based practice per the Guide to Physical Therapist Practice; adhering to ethical standards per the practice act of the APTA, etc.
Defining the Review

As stated earlier, the agency must define up front what the objective of the review is in order to correctly and efficiently detect any problems or confirm compliance.

Can start with a broad idea of:

- We want the documentation to stand up to MRA scrutiny

Home Health audit risk areas

- Homebound status
- Documentation of skilled care
- Expectation of improvement
  - Physician certification (orders, F2F)
  - Absent orders for delivered care
Homebound Status

- Is it enough to check the box that reads:
  - Absences from home require a considerable and taxing effort

We know that in November 2013, CMS clarified the guidance on homebound status, emphasizing it is to be more of a 2 step thought process⁷:
1. **Criteria-One:**
The patient must either:
- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence
**OR**
- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria-One conditions, then the patient **must ALSO** meet two additional requirements defined in Criteria-Two below.

2. **Criteria-Two:**
- There must exist a normal inability to leave home;
**AND**
- Leaving home must require a considerable and taxing effort.

### Homebound Status:
So from a reviewer’s standpoint, look to see if the documentation supports the boxes.

- ❑ Is it just a check box of some vague reason, or is there further elaboration?
- ❑ Does the rest of the documentation support what was stated?
- ❑ Is the homebound reason updated during the episode as the patient’s functional and medical status progresses?
- ❑ Or does it remain a “reasonable and taxing effort to leave the home” until the final visit, when they miraculously get better!
Documentation of Skilled Care

We often don’t document the countless “little things” we do and teach to reduce and prevent problems…the very things that are vital to showing medical necessity.

Medical necessity – does the documentation indicate:

- Why is home health seeing the patient?
- What is the focus of care?
- What services are needed to achieve the goals/outcomes?
- Are there any co-morbidities that may impact the outcome?
  - Is there documentation addressing the co-morbidity?

Expectation of Improvement

In order to determine the expectation of improvement, a thorough investigation into the PLOF is needed.

- How can you state with any degree of certainty if the goals are achievable or realistic if you do not have a clear idea of how they were functioning prior to the event that caused the need for medical intervention
Prior Level of Function

Upon initial evaluation, is there documentation indicating the prior status of:

- Cognition
- Functional abilities (all ADLs, including activity in the community)
- Hobbies
- Living arrangements

So, back to Expectation of Improvement

Knowing the full PLOF of the patient helps to guide your decision making not only of potential goals to set and the ability to reach them, but perhaps on whether or not the patient even needs to be seen for care.

Remember, one of the criteria auditors look at for reasonable and necessary is if the patient’s expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.
For example, a patient was admitted to home health PT for weakness related to progressive Parkinsons. PT had seen the patient for multiple episodes in the recent past, and the evaluation indicated the patient was at the functional level she was discharged at 3 weeks ago.

➢ PT admitted the patient for caregiver training, issue of HEP, strengthening and gait training.

➢ The episode was later denied by MCR, as the patient was at her baseline, her PLOF, and goals were not reflective of any significant change in functional status.

➢ The agency was denied payment of 14 therapy visits.
The Evaluation

• Is the evaluation comprehensive, performed to APTA and current CMS standards?
  • Comprehensive Systems Review
  • Determining Impairments
  • Use of Functional Tests and Measures
  • PLOF documented

Visit Documentation

Frequently observed documentation issues to be on the lookout for:
1. Vague documentation (e.g., ‘max assist for transfers’)
2. Conflicting documentation (e.g., ‘independent with SBA for ambulation’)
3. Restating same documentation every visit
   a. Repetitious visit notes that show no change in patient status
      *do not support continued treatment* (not deemed reasonable and necessary)
Visit Documentation

Each visit note must stand on its own, meaning that upon review of any visit note, the following should be identified:
- Change in patient status
- Interventions provided with patient response:
  - frequency,
  - intensity, and
  - duration as appropriate
- Factors for why frequency/intensity of the intervention was modified
- Progression of goals
- Plan for next visit

Visit Documentation

What is not “material improvement” or indicative of the need for continued care:
- Performing more reps of exercises
- Improvements that lack functional relevance
- Pain control, strength, ROM, endurance improvements without functional correlation
- Gains the patient cannot/will not sustain after therapist discharge

Does your review tool target these trouble spots?
Believe it or not, chart audits often find that a problem was documented, yet there was no indication that the therapist did anything to intervene and/or there was no information regarding the patient or caregiver’s response.

This also can lead to a determination that the therapy services are not reasonable and necessary and result in a denial of payment.

Functional Assessments

Don’t forget as well to review the Functional Assessments (FA)

Compliance review will target completion at the required time, but it is also crucial to be certain the FA contains the proper information:

The FA is to reflect the effectiveness of therapy performed by comparing the prior evaluation to the current functional evaluation via tests and measures.
FA – Key Components

1. Objective assessments. There should be a comparison from the prior evaluation or FA to the current assessment. It is important to show sequential objective measurements.

2. Expectation of progress. There must be a clinically supported statement indicating the patient will continue to show meaningful progress, or there is an expectation they will resume progress following a plateau or decline in function.

3. Support for effectiveness of care. Indicate how therapy provided is impacting the patient.

4. Plan to continue or d/c therapy. If the measurements do not indicate progress or effectiveness, documentation must be included reflecting collaboration between the MD and therapist of determination to continue.

5. New orders as needed (due to change in POC).
Reviewing a Chart for Quality

Pass RAC audit

Homebound Status
Focus on?

Document Skilled Care
Focus on?

Expectation of Improvement
Focus on?

Functional Limitations

- Amputation
- Bowel/Bladder (Incontinence)
- Contracture
- Hearing
- Paralysis
- Endurance
- Ambulation
- Speech
- Legally Blind
- Dyspnea with Minimal Exertion
- Other (specify):
  Activities Permitted
  - Complete Bedrest
  - Bedrest w/BRP
  - Transfer Bed/Chair
  - Exer. Prescribed
  - PWB
  - Wheelchair
  - AMB
  - Amb w/O2
  - Cane
  - Other (Specify):

Unusual Rehab Environment
one flight stairs in home

POC Established with:
- Patient
- Family
- Other

Home Bound status:
- Bed Bound
- Poor Limited Endurance
- Paralysis
- W/C
- Bound w/o access to stairs
- Confused/Disoriented
- Severe SOR, unsafe to leave home
- Unsteady gait/high risk for falls
- Cannot ambulate > 10'
- Others:
  - 20 ft.
### DX
leukemia

### ONSET
05/2013

### DATE OF BIRTH

### SIGNIFICANT MEDICAL HISTORY/ Pertinent Medications
- compression fx lumbar and thoracic spine

### Prior level of Function
- I with adl, t/f, bed mobs, gt

### Patient Goals: I want to walk better

### PROBLEMS
- dim gt
- dim t/f
- dim bed mobs
- dim strength
- dim balance, endurance, safety
- c/g tx and hep

### GOALS
- gt 50ft I
- t/f I
- bed mobs I
- 5/5 mm: BLE
- good balance, safety, endurance
- good return of skills hep and c/g tx

### EVALUATION: Functional Status

<table>
<thead>
<tr>
<th>Level of Assistance</th>
<th>Bed Mobility</th>
<th>ADL</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-Independent</td>
<td>Roll/Scoot Max</td>
<td>Dressing Max</td>
</tr>
<tr>
<td>S-Supervised Min</td>
<td>Sit Max</td>
<td>Personal Max</td>
</tr>
<tr>
<td>Min-Minimum</td>
<td>Supine Max</td>
<td>Hygiene Mod</td>
</tr>
<tr>
<td>Assistance</td>
<td>Transfer Max</td>
<td>Bathing Mod</td>
</tr>
<tr>
<td>Max-Maximum</td>
<td>Bed Max</td>
<td>Feeding Independent</td>
</tr>
<tr>
<td>Assistance U-Unable</td>
<td>W/C Not Tested</td>
<td>Meal Not Tested</td>
</tr>
<tr>
<td>NT-Not Tested</td>
<td>Toilet Max</td>
<td>Home Not Tested</td>
</tr>
<tr>
<td></td>
<td>Shower Max</td>
<td>Making Not Tested</td>
</tr>
<tr>
<td></td>
<td>Car Not TESTED</td>
<td></td>
</tr>
</tbody>
</table>

### EVALUATION: General Strength/ROM

<table>
<thead>
<tr>
<th>Cervical</th>
<th>Trunk</th>
</tr>
</thead>
<tbody>
<tr>
<td>wfl wfl</td>
<td>dim wfl</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extremities</th>
<th>Endurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>dim wfl</td>
<td>poor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Posture</th>
<th>Pain/Edema</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>guarded</td>
<td>4/10 back</td>
<td>poor</td>
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<table>
<thead>
<tr>
<th>Safety Measures</th>
<th>Cognition/Comm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equip in Home</td>
<td>Equip Needs</td>
</tr>
<tr>
<td>gpc</td>
<td>none</td>
</tr>
</tbody>
</table>

### Gait Description
- Analysis: patient amb with antalgic gait
- Levels Max Unsafe Surfaces
- Stairs Device

### EVALUATION: Cognition/Comm
- Grossly intact
- Sensory/Tone/Neuro grossly intact

### EVALUATION: Pain/Edema
- Headache, 4/10 back

### EVALUATION: Posture
- Scoliosis, 4/10 back
Homebound Status Review

- Is it just a check box, or is there further elaboration? Does it support the 2-step question per CMS?

- Does the rest of the documentation support what was stated?
Caregiver instructed to put a sign in the bathroom to cue the residents to apply the brakes prior to transferring to the toilet. Transfer training with verbal cueing for proper hand placement.

### A. BED MOBILITY

<table>
<thead>
<tr>
<th>Turn/Roll</th>
<th>Sit to Stand</th>
<th>CGA</th>
<th>Shower Tub</th>
<th>CGA</th>
<th>Propulsion Level Surfaces</th>
<th>IND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scoot / Bridge</td>
<td>Stand to Sit</td>
<td>CGA</td>
<td>Fall Recovery</td>
<td></td>
<td>Propulsion Uneven Surfaces</td>
<td></td>
</tr>
<tr>
<td>Sit to Supine</td>
<td>Stand / Pivot</td>
<td>CGA</td>
<td>Motor Vehicle</td>
<td></td>
<td>Safety Locks</td>
<td>VC</td>
</tr>
<tr>
<td>Supine to Sit</td>
<td>Toilet</td>
<td>CGA</td>
<td>Sliding Board</td>
<td></td>
<td>Foot / Leg Rests</td>
<td></td>
</tr>
<tr>
<td>Describe:</td>
<td>describe:</td>
<td>Other:</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>has hosp bed</td>
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<td></td>
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</tbody>
</table>

### D. GAIT / AMBULATION

<table>
<thead>
<tr>
<th>Wt Bearing Status</th>
<th>Surfaces</th>
<th>Assist</th>
<th>Distance</th>
<th>Assistive Device</th>
<th>Surfaces</th>
<th>Assist</th>
<th>Distance</th>
<th>Assistive Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>FWB, PWB, WBA, NWB, TTWB, RLE, RUE, LUE, LUE, Clear</td>
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</tbody>
</table>
Other Observed Gait Deviation (Describe): patient with decreased stride, hip and knee flexion

✓ Gait Training - To improve materially patient's ability to walk /restore functional loss (Describe):

✓ PTA1. Patient will demonstrate material improvement for safe gait in home on (✓ level, □ uneven) surfaces within # □ Visits.

✓ PTA2. Patient will demonstrate material improvement in fall frequency reduction within # □ Visits.

✓ PTA3. Patient will demonstrate material improvement with use of prescribed assistive devices within # □ Visits.

✓ PTF1. Patient/CG will demonstrate material improvement for safe transfers / Sit ↔ Stand within # □ Visits.

SUBJECTIVE: Language barrier, no complaint of pain

OBJECTIVE: CHANGE IN MEDICATIONS? ☐ Y ☐ N If yes, then communicate with SN/Case Mgr and list changes in CARE COORDINATION section below.

AMBULATION: 300 ft in hallways with rolling walker and caregiver. Patient instructed to keep walker locked so it gives her more support. Also decrease steps and slow down. Patient remains quite ataxic.

EXERCISE PROGRAM:
Supine (heel slides, hip abd, bridges) seated (L/AQ, hip flex), standing (squats, toe raises) x 15 reps.

OTHER:
Transfer Training - Impulsive, plops, unsteady
Compliant with BP - she is doing 2x a day
Documentation of Skilled Care Review

As we went through the various parts of this visit note, I think we found where the note leaves itself open to denial:

- Transfers: what is the CGA for, what was the response to the vc training, which transfer needed the training.
- Gait: what did the cga entail, why only 40 ft, any turns, SOB, etc.
- What do you think of the goals? What do you think an auditor will think of the goals? Do you think they can be measured and therefore documented as Met?
Pass RAC audit

Homebound Status
Focus on?

Document Skilled Care
Focus on?

Expectation of Improvement
Focus on?

PATIENT'S PRIOR LEVEL OF FUNCTION:
Independent without assistive device but has been getting weaker lately.

MEDICAL HISTORY:

- Stroke
- Alzheimers
- CHF
- Multiple Sclerosis
- Pressure Sores, Ulcers, Wounds, Infections
- Parkinson's Disease
- OA / DJD / RA
- COPD
- Muscular Dystrophy
- Seizures
- HTN
- PVD
- Asthma
- Spinal Cord Injury
- Head Injury
- DM
- Paralysis / Paresis # Extremities
- CAD
- Other brain surgery 2012
Expectation of Improvement Review

Did the initial evaluation document/determine a thorough prior status of:

- Cognition
- Functional abilities (all ADLs, including activity in the community)
- Hobbies
- Living arrangements
Putting it all together....
Visit Note Review –the basics:
1. Homebound Status

2. Documentation of skilled care
   • Change in patient status
   • Interventions provided with patient response:
     • frequency,
     • intensity, and
     • duration as appropriate
   • Factors for why frequency/intensity of the intervention was modified
   • Progression of goals
   • Plan for next visit
3. Expectation of improvement
Visit Note Review – digging deeper:

1. Is there an integration of the comorbidities with the functional status
2. Is there a synthesis of the goals with tests and measures being used
3. Was evidence-based practice use/documentated
4. Does the treatment performed align with the deficits/goals of the patient

“The Best Defense…..”

• They are going to come, try not to give them anything to keep them interested
• Be proactive NOW (if your agency has not already caught on to this)
  • Conduct chart reviews
    • Utilization
    • Patient documentation requirements
  • Conduct internal audits
    • If you find a thread to pull, develop a corrective plan of action
Questions?

Thank you very much for attending! Best of luck!

Resources and References