Home Health Documentation Risk Checklist

A practical audit tool to identify documentation gaps that commonly lead to claim holds, reimbursement reduction, and compliance exposure during chart review.

OASIS Documentation Risk Indicators

- OASIS responses are supported by clinician narrative documentation.
- Functional scoring aligns with visit notes and therapy documentation.
- Medication reconciliation matches physician orders and the EMR medication profile.
- Fall risk documentation supports OASIS scoring.
- Wound documentation aligns with OASIS wound items.
- ADL scoring reflects the patient's usual ability, not best performance.

Diagnosis and ICD-10 Coding Risk Indicators

- Primary diagnosis supports the skilled need for home health services.
- Diagnoses align with physician orders and the Plan of Care.
- Comorbidities are documented when they affect care or reimbursement.
- ICD-10 codes are reported to the highest level of specificity.
- Etiology and manifestation sequencing is correct when required.
- Chronic conditions are documented when they continue to affect care.

PDGM Reimbursement Risk Indicators

- Primary diagnosis supports the appropriate PDGM clinical grouping.
- Relevant comorbidities are captured when documented.
- Admission source is accurately documented.
- Episode timing is accurate, including early versus late.
- Functional impairment level is supported by assessment findings.
- Major conditions such as cardiac, respiratory, wound, and neurological issues are clearly documented.

Schedule a QA consultation

If your agency is seeing billing delays, QA backlog, or documentation inconsistency, Avory Home Care Solutions can help.

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Additional Risk Areas and Action Steps

Use this page to strengthen internal QA processes, reduce avoidable denials, and support cleaner claim submission.

Clinical Documentation Risk Indicators

- Skilled need is clearly documented in clinician notes.
- Narrative explains why services require a licensed clinician.
- Physician orders support all services delivered.
- Progress toward measurable goals is documented.
- Patient and caregiver education is documented.
- Response to treatment and significant clinical changes is documented.

Compliance and Audit Risk Indicators

- Homebound status is clearly described.
- Face-to-face encounter documentation is present.
- Physician certification is completed and signed.
- Plan of Care aligns with clinician assessment findings.
- Orders are signed, dated, and current.
- Care coordination is documented when multiple disciplines are involved.

Best Practices to Reduce Documentation Risk

- Ensure OASIS responses match clinician narrative and therapy documentation.
- Capture all active comorbidities affecting patient care.
- Verify ICD-10 specificity and sequencing before claim submission.
- Confirm documentation supports skilled need and homebound status.
- Conduct internal QA review before billing whenever possible.

RN-Led QA Support Available

- OASIS QA Review
- ICD-10 Coding Validation
- Full Chart Review
- Pre-Billing Quality Assurance
- Compliance Risk Identification

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