



Compliant Clinical Documentation and Face-to-Face

Prevention is Best



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Presented by *Arlene Maxim RN, HCS-C*



With more than 40 years of nursing experience, Arlene previously co-founded a regional multi-million dollar Medicare certified home health care companies, hospital-based homecare and hospice companies, and transitional care programs. Early in her nursing career she combined her clinical knowledge with her homecare/hospice interests and began working as a consultant in the homecare and hospice field.

She is a well-known on the national front and is a frequently sought after speaker in all areas of patient care quality, analysis, and administrative functions in the post-acute healthcare world. She served as a Board Member and Vice Chair for the Association for Homecare/Hospice Coding and Compliance out of Gaithersburg, Md. From 2011-2024. Arlene is also honored to hold Board positions with Narx in Vineyard, Utah and Connected Home Living from Los Galos, California, Senior Home Services, Inc., The Cancer Safety Net Foundation and currently functions as a Senior Consultant for one of the largest home health and hospice EMR companies in the nation.

The 2024 Gold Stevie® Award for Female Thought Leader of the Year
2025 McKnight's Women of Distinction Commercial Excellence Award.



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Overview

In the crowded world of Medicare Medical Review are many ways to lose payment for provided service. This presentation addresses agency actions (or lack of) that generate common denials. These span MAC, UPIC, SMRC, and RAC audits. Recognizing risky macro (utilization, EMR) and micro (visit documentation) patterns affords the home health agency the best chance to minimize negative effects (denials) from medical review. Also applies to Medicare Advantage reviews. Knowledge + teaching = prevention.



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Learning Objectives

- At the completion of this educational activity, learners will be able to:
1. Define technical versus medical denials
 2. Identify the five requirements for certification and recertification
 3. Identify denial reasons from admission documentation and actions to prevent
 4. Identify denial reasons during care provision and actions to prevent
 5. Identify denial reasons during recertification and actions to prevent
 6. Identify how EMR and AI aide or may cause denials



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Medical Review (MR)

- The purpose of medical review is to determine if PAYMENT is proper
 - patient eligibility requirements are met
 - technical requirements (orders, certifications) met
 - service provided was needed
- It's a FINANCIAL determination—this is separate from SURVEY compliance
- It's conducted to determine if the record supports payment either
 - before final payment is made (pre-payment review)
 - on reopened prior billed and paid claims (postpayment)
- Focuses on areas identified as high risk to the Medicare trust fund or insurance payer (high volume, problem prone)
- Links the CONTENT of the record with the REQUIREMENTS for payment
- Demonstrates the importance of daily consistent compliance with coverage and payment requirements on all records in event a review is triggered



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Denials

Technical

- Objective
- Timeliness of documents/billing
- Lack of orders
- Missing/incomplete certification requirements
- Billing requirements not met
- Certification requirements not met

Medical

- Subjective
- Open to interpretation if coverage requirements met
- Question if skilled care was needed and provided
- Medical necessity of care
- Mostly Medicare Benefit Policy Manual (MBPM) based



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Key Charting Compliance Time Points

- Infrastructure/training (EMR, staff knowledge, orientation)
- Admission/chart creation (start of care)
- During care delivery (all ongoing care, recertifications)
- End of care and record closure (discharge)



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The Goal of Home Health

- Deliver the **right amount of care** based on patient need and eligibility
- Ensure the **right reason for care** is clearly documented for the **right patient**
- Utilize the **right disciplines at the right time** to meet regulatory requirements
- Align care delivery with **regulatory compliance** to support accurate reimbursement
- Focus on achieving **optimal patient outcomes** while supporting appropriate payment
- Emphasize that **preventing compliance issues** is more cost-effective than managing denials and appeals
- Once services are billed, the priority is to **protect and retain payment** through strong documentation and compliance



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Medical Reviewers for Michigan

- National Government Services (NGS) Jurisdiction 6 (J6) – Targeted Probe and Educate (TPE)
- UPIC: Unified Program Integrity Contractor (Midwest Region) – UPIC audits
 - Coventbridge
 - <https://www.coventbridge.com/midwest-upic>
- SMRC: Supplemental Medical Review Contractor – SMRC focused audits
 - Noridian Healthcare Solutions
 - <https://www.noridian-smrc.com>
- RAC: Recovery Audit Contractor – RAC audits
 - Cotiviti (Region 5 National DME/HHH)
 - <http://www.cotiviti.com/RAC>
- CERT: Comprehensive Error Rate Testing contractor – general payment reviews
 - <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Improper-Payment-Measurement-Programs/CERT>
- Medicare Advantage plans – plan specific audit activity
 - Humana, United Healthcare, Blue Cross/Blue Shield, Cigna, Aetna, Meridian, etc.



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Infrastructure / Training Issues

Establishing a Foundation for Success



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Electronic Medical Record Systems Issues #1

- Electronic medical record (EMR) system doesn't follow applicable rules/regulations
 - EMR clearly integrate and prompt compliance with skilled care requirements
 - Have strong security .built into software
- Difficult to read: type size, formatting, paragraph breaks, pagination, location of information (use of addendum pages versus in its related section)
- Clutter: too much content in Plan of Care and too many goals



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Electronic Medical Record Systems Issues #2

- Clutter: too much content in visit note to expect it was all covered within the visit (too many check box and generic statements, interventions)
- Repetitive interventions, goals
- Does not contain required assessment/note components (e.g. therapy reassessment comparison to prior assessment; plan for next visit)
- Stilted (what does this mean?) /cumbersome language (e.g., "Instruct patient/caregiver on...") that reflects generic charting



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Electronic Medical Record Systems Issues #3

- Check-boxes ALONE will NEVER generate a compliant note
- Check box/drop down options: generic content is not clearly relatable to the specific patient status
- Summaries (especially 60-day and recertification) are full of generic phrases and check boxes
- Populates identical narrative multiple places in the record (does not make it any more correct by repeating it)
- Provides generic phrase options: "teach disease process", "Condition unstable", etc.
- Homebound options are generic check-boxes
- TOO MANY CHOICES of NON-SPECIFIC CONTENT



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Prevention: EMR and Compliance

- EMR systems provide **templates** for OASIS, assessments, visits, summaries, communications, and orders
- An EMR alone **does NOT ensure a compliant or fully payable claim**
- **Narrative content is essential**—templates must be supported with clear, patient-specific documentation
- Clinicians must be educated on **CMS requirements** (CFR, Medicare Benefit Policy Manual)
- Provide staff with **real examples** of how to document key coverage requirements within your EMR
- Strong staff understanding of requirements helps **optimize EMR use** and supports compliant documentation



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Agency/Staff Knowledge Deficits Cause...

- Non-compliant F2F encounters to be accepted as valid
- Stable patients- show no continued care need are recertified
- Long/repeated time on service for same or similar diagnoses
- Generic, repetitive, and unneeded teaching
- Generic goals that do not address focus of care
- Incomplete therapy reassessments and comparisons
- Care generates its own momentum—not addressing a need



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...Resulting in Poor Charting

- Templates used for documentation (entire sections identical from note to note)
- Copy/paste from note to note, Plan of Care to Plan of Care ("cloned" charting)
- Medications are not classified as "new" or "changed" (e.g. all meds are "new")
- OASIS scoring not supported by medical record (M1033, ADLs M1800-1860)
- OASIS GG-Items contradict M-items (functional status)
- Inconsistent data identifying F2F encounter type (audio/video of telemedicine visit)
- Key components showing skilled care are not documented (skilled care from CFR and MBPM)



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Training Issues: Unfocused Care

- Cloned documentation (identical notes and services, visit to visit, patient to patient)
- Lack of Therapy Services when diagnosis would support it (e.g., Neuro-Rehab clinical grouping, musculoskeletal diagnoses, but no therapy provided)
- Interventions "seem" to apply—but are generic to all home health patients
- ALL medications or ALL diagnoses are addressed (dilutes focus on primary diagnosis and new/changed medications)
- Teaching is generic ("disease process") or repetitive (on "old" chronic diagnoses) or unskilled (e.g., comply with medical appointments and take medications as ordered).
- Service Times (all visits same length; times overlap for patients in same location)



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Home Care Delivery: The Purpose of Visits

ALL VISITS MUST HAVE PURPOSE

- They fit into a realistic plan of care
- They address the focus of home health
- They identify any new issues and follow-up on them
- They document skilled reasonable and necessary actions
- They do not continue longer than necessary
- They address issues that home health can affect
- They involve the patient/caregivers to the greatest extent possible



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Prevention: Improved Staff Knowledge

- IF YOU KNOW IT—YOU CAN CHART IT
- For all EMRs: know what is expected in rules and regulations
- Demonstrate the application of coverage requirements in the clinical record: OASIS, assessments, visit notes
- Develop a realistic patient needs-focused plan of care
- Maintain unity of purpose while keeping the “big picture” in mind
 - visits show skilled care focused on goal achievement
- Recognize when it’s time to discharge—and do so



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Plan of Care, and Visit Notes

- Prioritize **quality of care over visit volume**—ensure services are appropriate for the specific patient
- Avoid “**click and clutter**”—limit selection of unnecessary or generic options
- A **generic Plan of Care** does not support medical necessity or reimbursement
- Develop a **patient-specific Plan of Care** and ensure all visits align with ordered services
- Eliminate **boilerplate documentation (“note bloat”)** that is not individualized to the patient
- **Customize documentation** to reflect actual care provided and patient response
- Use **clear narrative** to individualize notes and address patient-specific needs
- Evaluate documentation: is it **specific and skilled**, or just generic phrasing?
- Validate EMR-generated interventions—ensure they are **reasonable, necessary, and patient-specific**
- Ensure staff understand and apply **key coverage rules and regulations** at orientation and ongoing training



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MBPM Pub. 100-02, Chapter 7 Key Regulations

- 30.1 Confined to Home
- 30.2 Services under a Plan of Care
- 30.3 Under the Care of a Physician/Allowed Practitioner
- 30.4 - Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample), Physical Therapy, Speech-Language Pathology Services, or Has Continued Need for Occupational Therapy
- 30.5.1 Certification
 - 30.5.1.1 Face-to-Face Encounter
 - 30.5.1.2 Supporting Documentation
- 30.5.2 Recertification
- 30.5.3 Who May Sign the Certification or Recertification
- 40.1.1 Skilled Nursing Service
 - 40.1.2.1 Observation / Assessment
 - 40.1.2.2 Management & Evaluation
 - 40.1.2.3 Teaching/Instruction
 - 40.1.2.4 Medication Administration
 - 40.1.2.7 Catheters
 - 40.1.2.8 Wound Care
 - 40.1.2.13 Venipuncture
 - 40.1.2.15 Psychiatric
- 40.2.1 Skilled Therapy Services
- 50.2 Home Health Aide Services
- 50.3 Medical Social Services



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Key Code of Federal Regulations (CFR)

- 42 CFR 409.33: Examples of skilled services and the need for skilled services
- 42 CFR 409.41: Requirement for payment
- 42 CFR 409.42: Beneficiary qualifications for coverage of services
- 42 CFR 409.43: Plan of care requirements
- 42 CFR 409.44: Skilled services requirements
- 42 CFR 409.45: Dependent services requirements
- 42 CFR 409.48: Visits
- 42 CFR 424.22: Requirements for home health services
- 42 CFR 484.55: CoP, Comprehensive Assessment
- 42 CFR 484.60: CoP, Care planning coordination of services, and quality of care (INCLUDES REQUIRED PLAN OF CARE CONTENT)



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Other Applicable References

- 42 CFR 484.75: Skilled Professional Services
- CMS OASIS Guidance Manual
- ICD-10 Official Guidelines for Coding and Reporting



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Medicare Program Integrity Manual (PIM)

- Internet-Only Manual (IOM), Publication 100-08
- Chapter 3: Verifying Potential Errors and Taking Corrective Actions
- Chapter 6: Medicare Contractor Medical Review Guidelines for Specific Services



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Admission issues

Start Charting Right



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Admission/Chart Generation Failures #1

- Plan of Care is missing attestation/certification (verbiage)
- Certifying physician/allowed practitioner did not document the date of the F2F encounter
- No link shown between non-physician practitioner (NPP) and certifying physician (different between F2F and PoC)
- Agency clinical records used to support F2F/homebound not identified/integrated with certification



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Admission/Chart Generation Failures #2

- Nursing assessments do not correlate to therapy assessments (findings contradict—especially ADLs)
- Primary diagnosis is not related to F2F content
- Primary diagnosis is not clear in Plan of Care (focus of care)
- Goals are not related to primary diagnosis
- Goals are non-measurable/without expected date of accomplishment
- Nursing doing OASIS when referral is therapy-only



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Admission/Chart Generation Failures #3

- Functional Status scoring on OASIS not supported by narrative findings (ADLs M1800-M1860)
- OASIS Risk for Hospitalization M1033 not supported by findings
- OASIS GG items inconsistent with functional M-items (ADL) scoring
- A reason/need for home health is not clearly documented
- Body system assessments show no current issues/problems
- For readmission to care: reason is not clear (why are they back on service now? What changed?)



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Failure Patterns During Admission

- Principal Diagnoses not changing (similar on multiple claims, over multiple periods)
- Lack of Therapy Services with Diagnosis showing need (Neuro-Rehab clinical grouping, musculoskeletal diagnoses, but no therapy)
- Readmissions (restarting home health service, service break just long enough for episode timing reset)
- Delays of Care (Time between F2F and start of care, therapy evaluations, referral to admission) not explained or addressed
- Claim is coded without access to/integrating the F2F encounter
- Plan of Care is certified/signed before F2F encounter is completed



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Face-to-Face Encounter Issues

- Top denial reason since implemented in 2011
- 2015 revision removing narrative requirement did not result in improved compliance
- If defective, can result in all subsequent service being denied
- If not correct at admission, virtually impossible to "fix" or amend later



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Face-to-Face Basics

- Up to 90 days prior to admission and 30 days after admission
- Performed by physician/allowed practitioner or non-physician practitioner (NPP) working with a physician
- Is related to the primary reason the patient requires home health services
- Content of encounter supports a conclusion of homebound status
- The PoC certifying physician/allowed practitioner documents the date of the encounter



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Face-to-Face Compliance

- EVERY F2F is checked at time of admission
- If there is a change in condition since F2F encounter and admission, have 30-days to obtain a NEW encounter to address the current condition
- BEWARE of CODING conventions compared to COMPLIANCE content. Correctly coded claims can still generate denials.
- Medical reviewers are not coders: they follow MBPM, CFR



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Face-to-Face Compliance

- Indicate in certification statement the date of the F2F encounter
- Match the certified date of encounter to actual note from encounter
- Incorporate the F2F encounter in coding/diagnosis selection process
- Review that findings of F2F support a conclusion of homebound
- Incorporate agency generated documents to supplement F2F items used (integrate them with signature of review, etc.)
- Performed by an ALLOWED PRACTITIONER
 - 2026 change: if admitted from facility, no longer must be someone with privileges in an acute or post-acute facility from which the patient was directly admitted to home health (if different than the certifying physician or allowed practitioner)



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Face-to-Face and Telehealth

- Final Rule 2026 extended telehealth capability for home health F2F encounters through end of 2027
- F2F encounter must still clearly include BOTH audio and visual content
- The method of interaction (both audio and visual) on encounter documents must be abundantly clear—not just audio or via telephone
- Telehealth encounters present challenges to physical assessment content and review of systems (as the patient is not physically present with the physician/allowed practitioner)



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Certification and Recertification

- In 42 CFR 424.22
- In IOM MBPM 100-02, Chapter 7, Sections 30.5.1, 30.5.2, 30.5.3
- Certification verbiage must be present (usually incorporated into the Plan of Care)
- Homebound
- Under care of a physician/ allowed practitioner
- Periodic review of plan of care
- In need of skilled care
- Carfe provided by certified agency



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Denial Prevention: Plan of Care

- Questions:
- Does the Plan of Care include all required components?
 - Does the Plan of Care address the principal diagnosis (focus of home health)?
 - Is the Plan of Care reasonable to be performed within the ordered frequency?
 - Is the Plan of Care individualized to patient needs?
 - Are the goals from care reasonable and related to patient needs?
 - Does the Plan of Care mesh (via EMR) with the visit notes?
- Takeaway: the Plan of Care must be demonstrated and implemented during home health service so it must be relevant and realistic



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Denial Prevention: Assessments

- Admission care conference with admitting clinician and supervisor
- Admission care conference between disciplines (focus on assessment consistency)
- Assessment shows findings related to the principal diagnosis (focus of home health)
- Assessment identifies chronic/old issues compared to acute/new issues
- "Exacerbations" are supported by findings in the record
- Clear link between assessment and Plan of Care is shown
- Coders have access to assessments and F2F
- Takeaway: the Assessment must justify and show the need for service



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During care delivery

Keeping Up Good Charting



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Technical Record Failures

- Orders are not dated when signed
- Stamped signatures/dates
- Electronic signatures are not identified as such
- No credentials for clinician or allowed practitioner
- Type of visit billed does not match correct discipline (therapy assessments/reassessments; visit notes)



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Denial Reasons During Care #1

- No 30-day therapy reassessment (not present, or lack of content if present)
- Recertification: no documentation of "hand-off" when change in certifying physician/allowed practitioner for new certification period
- Orders lack time recorded (a Condition of Participation requirement)
- Orders for services are incomplete (lacks frequency AND duration, specify if day/week/month)
- PRN visits lack specificity for when may be used
- PRN visits are provided outside of established reasons



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Denial Reasons During Care #2

- Nursing/therapy service is custodial/unskilled
 - repetitive, reinforcing prior instruction or skills/could be transferred to a caregiver
- Nursing and therapy assessments vary with their findings
- Recertified at 1x/week frequency
- Recertified for 3+ certification periods without a chronic recurring condition (urinary catheter, insulin injections, etc.)



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Denial Reasons During Care #3

- Duplicate visits (in a day) without reason identified
- Overlapping visit times without reason identified
- Therapy maintenance plan of care without matching interventions/goals/rationale (shift in focus of care from restorative to maintaining function)
- Therapy Plan of Care is restorative, but a maintenance care provided (or vice-versa)



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Denial Prevention: Making Valid Visits

ALL VISITS MUST HAVE THE CARE PROVIDED DOCUMENTED

- They follow the realistic plan of care
- They show what care is being provided for the primary diagnosis
- They identify when new issues arise and show follow-up on these
- They document skilled reasonable and necessary actions
- They address issues that home health can affect (make a change)
- They document status of any caregivers related to care
- They follow technical requirements (Plan for Next Visit, objective assessment findings, etc.)



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Plan of Care and Visit Notes

- Resist marking too many generic options: creates "click and clutter"
- A generic EMR template plan of care does not support reimbursable visits
- Many EMRs provide detailed intervention content (especially on teaching)—need to evaluate if this is specific to the patient need and if it is reasonable and skilled
- Visits must follow the plan of care:
 - Avoid creating a record full of boilerplate (stock language identical for all documents but not specific to patient): "note bloat"
 - Customize visit documentation to describe what is to be actually performed
 - Use narrative content to individualize the note and address issues
- Consider what is actually being recorded: specific or generic phrases?



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Required: Nursing Longitudinal Charting

Home health clinical notes must document, as appropriate:

- The history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- The patient/caregiver's response to the skilled services provided, and
- The plan for the next visit based on the rationale of prior results,
- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- The complexity of the service to be performed, and
- Any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care.

Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following **would not adequately describe** the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC



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Nursing Observation and Assessment

- Valid for up to 3 weeks:
 - From start of care
 - May apply to later changes in condition, medication, or treatment
- Not automatically covered for this initial period: must show need for service
- Then must demonstrate potential for continued change or instability AND need for nursing to evaluate these changes
- Changes in condition support continued coverage
- Lack of change in condition = custodial
- Changes in condition without change in plan of care = non covered (if found to be a long-standing pattern)



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Nursing Teaching and Training

- There is no specific limit to length of teaching/training
- Often supports coverage after observation/assessment is no longer valid
- On new/changed treatments, medications, or diagnoses
- Limitations on recipient's learning ability must be identified
- Content of training must support the skills of a medical professional are needed
- Not all medications/diagnoses need instruction
- Response and progress of teaching must be recorded
- Limited coverage for performing reinforcement and re-training



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Denial Prevention: Management & Evaluatic

- Nursing skill only (not therapy)
- Evaluation of the care plan—not the patient
- Nursing is needed to manage unskilled care to prevent decline in patient condition
- Nursing service itself is not the skill—it is the supervision and interaction with unskilled caregivers
- A physician/allowed practitioner narrative statement is required on the recertification Plan of Care for Management and Evaluation patients
- Registered Nurse only: not LPN



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Denial Prevention: Wound Care

- Wound care must be complex (more than just skin breakdown or open)
- Simple presence of a wound does not result in coverage
- Care cannot be safely performed by non-medical person
- Plan of care must contain details of ordered treatment
- Post-operative wounds must still have complications or underlying disease that impair healing
- Document status of wound at least weekly (in detail)
- If daily care, must establish a reasonable and finite end of daily care date (if daily care over 3 weeks in length)



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Therapy Service Overview

- Restoration of Function
- Establishing a Maintenance Plan
- Performing a Maintenance Plan
- Therapy is **not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function** (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury.



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Required: Therapy Visit Notes

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.



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Maintenance Therapy Visit Notes

When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- The complexity of the service to be performed, and
- Any other pertinent characteristics of the beneficiary or home.



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Denial Prevention: Skilled Therapy #1

- Restorative or maintenance service is specified
- Document objective/measurable baseline findings
- Record objective successive measurements
- Make comparison of successive findings (30-day reassessments, discharge/end of care status)
- Provide more than just teachable exercises
- Address more than ambulation, strength, endurance (why meaningful to patient)



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Denial Prevention: Skilled Therapy #2

- Changes in condition resulting from therapy interventions are documented
- Identify the Prior Level of Function (for restorative plans)
- Be goal focused: record any progress (or lack thereof), rehab potential
- Document why skilled therapy intervention is needed (beyond providing a HEP)
- Address more than "general welfare" or improvement
- Show more than a list of deficits (pain, bed mobility, transfers, balance, ambulation, endurance) without any explanation why these are important and relevant to therapy treatment



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Reasonable and Necessary Care

- Nursing is covered when the patient is showing instability and changes with nursing interventions in response to the changes
- Therapy is covered when the patient is showing changes as a result of therapy: progress (unless on a maintenance program)
- Home health aide, medical social services are dependent to primary service (SN, PT, SLP, continuing OT)



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Recertification Patterns Causing Denials

- No change in diagnosis
- No change orders in prior certification period
- New period at 1x/week frequency
- No new/changed medications
- Change in diagnosis not matched by Plan of Care changes
- No clear identification why teaching is needed to continue
- No out-of-range parameters
- Continue generic interventions that should have been addressed on admission and prior period
- Therapy: no documentation of progress made in prior period



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At end of Care

Finish with Compliance



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End of Care Denial Reasons

- Billed visits do not match notes (a note for every visit)
- Discharge with "Goals Met" but sudden and unsupported
- Status of all goals not recorded at discharge (actual status, not just outcome if met)
- All orders not signed in record prior to final billing
- OASIS not in iQIES prior to final billing



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Overall Prevention: Actions for Success

- Focus QA/QI activity in areas of high non-affirmation
- Determine items needing 100% review and spot-check the remainder
- Review key documents (e.g., F2F, signed orders) when received
- Before final billing, check key compliance areas (orders, OASIS submission)
- Educate staff on CMS and MAC documentation requirements
- Educate physicians/referral sources on home health documentation needs
- Develop a culture of pre-claim review—once billed, it's too late!



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Where AI is Being Used in Health Care

- Government analytics (claims reviews, ADRs, PEPPER, etc.)
- Audio transcription services (Robin, DeepScribe)
- Electronic medical record (EMR) data analysis
- New companies are interfacing with EMR systems
- Many EMRs are adding AI features.
- Many Medicare Advantage claim reviews use some form of AI



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AI Considerations

AI is Good At

- Processing large amounts of data to make specific decisions or take specific actions fast
- Generating predictions when no clear workflow or procedure is present (machine learning)
- Identifying patterns in complex data (machine learning)

The Issue

- How the AI platform and human input interact in the provision of home health care is an unanswered question
- AI offers the possibility of improving care and outcomes, but the full implementation and implications of this are still not known



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Limitations of AI

- Data used to make decisions must originate in the clinical and administrative record.
- The majority of this is created by staff (i.e., humans)
- *If the data used to evaluate and generate the AI output is incomplete or flawed, there is little chance of a viable and successful outcome*
- AI may make suggestions for visits, content to be addressed, or interventions
- The application of these suggestions and guidance is still an actual staff function.
- The content of the clinical record must still be accounted for by a human clinician who authenticates the chart entry
- AI cannot replace positive, knowledgeable HI [HUMAN INTELLIGENCE]
- AI cannot sign the clinical record: clinicians are responsible for legal entries
- AI decisions are ONLY BE AS GOOD AS THE SOURCE: the CLINICIAN DOCUMENTATION



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Conclusion

- Learn from the experiences of others: PREVENTION
- Apply knowledge of what constitutes skilled care to charting
- Go beyond EMR check-box/drop down options when charting
- All care provided is linked to orders and goals
- Better patient and agency outcomes are obtained (HHVBP)
- Any Medical Review triggered does not generate denials
- Money billed is not taken back: KEEP YOUR PAYMENT




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CONTACT INFO



 info@gatewayhhc.com

 www.gatewayhhc.com

 (248) 230-9588