Guideline to Complete the ADR

Bagher Habibi, Consultant

1. Download the request by CMS of the 5 Patients
2. Send each Patient ADR separately Certified with return receipt
3. Ensure that the Medical Record has the following items
    a. Cover sheet with the following items: **(See sample below)**
        i. Name, title address, phone, fax email of the agency contact person
        ii. Patient Name, HIC number, DOB, episode requested
        iii. List of requested items including page number
    b. Paginate the complete Medical record
    c. Complete record for the specific Episode as requested by CMS
        i. All applicable physician signed plans of care (485) for the claim period
            1. Sign and **dated** by MD
        ii. All signed physician orders pertaining to the plan(s) of care
            1. Sign and **dated** by MD
        iii. Clarification of **homebound status** **(See MLN below page 2)** , including **functional and activity limitations**
        iv. Please include all OASIS forms pertinent to the claim period
        v. Documentation for each discipline billed, including:
            1. Notes and flowsheets
            2. Initial evaluations and reevaluations
            3. Summary reports
        vi. Physician documentation predicting the length of time needed for daily skilled nursing care and certification **(See MLN below page 6 clause # 3)**
        vii. Face to Face encounter documentation certified by the physician **(See MLN below page 4-6)**
        viii. List of itemized charges

            1. Supplies
            2. DME-include medical explanation of necessity with any supporting documentation
            3. Wound supplies
        ix. If there is an ABN on file, please provide

4. All signatures must be legible for all the providers of service (MD, RN, LVN, CHHA, PT, OT, ST, MSW, RD, etc…)
5. If signature is not legible, that is it is a symbol rather than a spelled out name , then attach a signature log
    a. Example of Illegible signature

Fig. 1: Illustrations of possible signatures

    b. Example of Legible signature

6. Stamp signature are not acceptable
7. Electronic signatures are acceptable, attach an attestation LOG
8. Notes:
    a. Technical Denials- Not appealable
        i. Signatures are not legible
        ii. Signatures without Date
        iii. Title of the provider of service is missing
        iv. F2F not complete and does not contain MD/Hospitalist progress note which matched the F2F date See CMS rule below p
        v. Recertification order does not contain estimation of number of future recertification needed
    b. Other denials
        i. No Skill Necessity

ii. Not Homebound
iii. Incomplete record

Sample Signature Log

Agency Letter head

I, Dr (or RN, PT etc…) ___________________________ attest that the following is my signature used to sign the medical record for the agency_________________

____

Signature

I, Dr (or RN, PT etc…) ___________________________ attest that the following is my signature used to sign the medical record for the agency_________________

____

Signature

I, Dr (or RN, PT etc…) ___________________________ attest that the following is my signature used to sign the medical record for the agency_________________

____

Signature

I, Dr (or RN, PT etc…) ___________________________ attest that the following is my signature used to sign the medical record for the agency_________________

____

Signature

Sample Signature Log/Electronic Signature log

Agency Letter head

I, Dr (or RN, PT, CHHA, LVN, etc…) attest that I use electronic signature to sign all the medical records for agency ____________________________________

____

Signature

I, Dr (or RN, PT, CHHA, LVN, etc…) attest that I use electronic signature to sign all the medical records for agency ____________________________________

____

Signature

I, Dr (or RN, PT, CHHA, LVN, etc…) attest that I use electronic signature to sign all the medical records for agency ____________________________________

____

Signature

I, Dr (or RN, PT, CHHA, LVN, etc…) attest that I use electronic signature to sign all the medical records for agency ____________________________________

____

Signature

Sample Cover Letter for ADR

Agency Letter head

Agency Contact person

Name, title:___________________________________

Address: _____________________________________

Phone and Fax : ___________________ ___________________

Email: _________________________________

Patient Name: ________________________________

HIC # : _______________________

Episode Dates from _______________ to _______________

i. Summary of Skilled Services : ____ ____ ____ ____ ____________
ii. All applicable physician signed plans of care (485) for the claim period (page # _____)
iii. All signed physician orders pertaining to the plan(s) of care (page # _____)
iv. Clarification of **homebound status** (page # _____) , including **functional** (page # _____) **and activity limitations** (page # _____)
v. All OASIS forms pertinent to the claim period (page # _____)
vi. Documentation for each discipline billed, including:
vii. Notes and flowsheets (page # _____)
viii. Initial evaluations and reevaluations (page # _____)
ix. Summary reports and Case Conferences (page # _____)
x. Physician documentation predicting the length of time needed for daily skilled nursing care (page # _____)
xi. Face to Face encounter documentation certified by the physician (page # ____)
xii. List of itemized charges
    a. Supplies (page # _____)

b. DME-include medical explanation of necessity with any supporting documentation (page # _____)
c. Wound supplies (page # _____)

xiii. ABN (page # _____)
xiv. NNC (page # _____)
xv. DC Summary and Instruction (page # _____)

Signature : Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN)

- **"Safeguarding Your Medical Identity"** Web-based Training (WBT)

MLN Matters® Number: SE1436	**Related Change Request (CR) #: NA**
Related CR Release Date: NA	**Effective Date: NA**
Related CR Transmittal #: NA	**Implementation Date: NA**

Certifying Patients for the Medicare Home Health Benefit

Provider Types Affected

This MLN Matters® Special Edition (SE) 1436 is intended for Medicare-enrolled physicians who certify patient eligibility for home health care services and submit claims to Medicare Administrative Contractors (MACs) for those services provided to Medicare beneficiaries.

What You Need to Know

This MLN Matters® SE1436 article gives Medicare-enrolled providers an overview of the Medicare home health services benefit, including patient eligibility requirements and certification/recertification requirements of covered Medicare home health services.

Key Points

To be eligible for Medicare home health services a patient must have Medicare Part A and/or Part B per Section1814(a)(2)(C) and Section 1835(a)(2)(A) of the Social Security Act (the Act):

- Be confined to the home;

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- Need skilled services;
- Be under the care of a physician;
- Receive services under a plan of care established and reviewed by a physician; and
- Have had a face-to-face encounter with a physician or allowed Non-Physician Practitioner (NPP).

Care must be furnished by or under arrangements made by a Medicare-participating Home Health Agency (HHA).

Patient Eligibility—Confined to Home

Section 1814(a) and Section 1835(a) of the Act specify that an individual is considered "confined to the home" (homebound) if the following two criteria are met:

First Criteria One of the Following must be met:	**Second Criteria** Both of the following must be met:
1. Because of illness or injury, the individual needs the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person to leave their place of residence.	1. There must exist a normal inability to leave home.
2. Have a condition such that leaving his or her home is medically contraindicated.	2. Leaving home must require a considerable and taxing effort.

The patient may be considered homebound (that is, confined to the home) if absences from the home are:

- Infrequent;
- For periods of relatively short duration;
- For the need to receive health care treatment;
- For religious services;
- To attend adult daycare programs; or
- For other unique or infrequent events (for example, funeral, graduation, trip to the barber).

Some examples of persons confined to the home are:

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain and therefore their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time or walking stairs only once a day; and

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- A patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Patient Eligibility—Need Skilled Services

According to Section 1814(a)(2)(C) and Section1835(a)(2)(A) of the Act, the patient must be in need of one of the following services:

- Skilled nursing care on an intermittent basis (furnished or needed on fewer than 7 days each week or less than 8 hours each day for periods of 21 days or less, with extensions in exceptional circumstances when the need for additional care is finite and predictable per Section 1861(m) of the Act);
- Physical Therapy (PT);
- Speech-Language Pathology (SLP) services; or
- Continuing Occupational Therapy (OT).

Patient Eligibility—Under the Care of a Physician and Receiving Services Under a Plan of Care

Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act require that the patient must be under the care of a Medicare-enrolled physician, defined at 42 CFR 424.22(a)(1)(iii) as follows:

- Doctor of Medicine;
- Doctor of Osteopathy; or
- Doctor of Podiatric Medicine (may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law).

According to Section 1814(a)(2)(C) and Section 1835(a)(2)(A) of the Act, the patient must receive home health services under a plan of care established and periodically reviewed by a physician. Based on 42 CFR 424.22(d)(1) a plan of care may not be established and reviewed by any physician who has a financial relationship with the HHA.

Physician Certification of Patient Eligibility

As a condition for payment, according to the regulations at 42 CFR 424.22(a)(1):

- A physician must certify that a patient is eligible for Medicare home health services according to 42 CFR 424.22(a)(1)(i)(v); and
- The physician who establishes the plan of care must sign and date the certification.

The Centers for Medicare & Medicaid Services (CMS) does not require a specific form or format for the certification as long as a physician certifies that the following five requirements, outlined in 42 CFR Section 424.22(a)(1), are met:

1. The patient needs intermittent SN care, PT, and/or SLP services;
2. The patient is confined to the home (that is, homebound);
3. A plan of care has been established and will be periodically reviewed by a physician;

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4. Services will be furnished while the individual was or is under the care of a physician; and
5. A face-to-face encounter:
   a. Occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care;
   b. Was related to the primary reason the patient requires home health services; and
   c. Was performed by a physician or allowed Non-Physician Practitioner.

Note: The certifying physician must also document the date of the face-to-face encounter.

According to the regulations at 42 CFR 424.22(a)(2) physicians should complete the certification when the plan of care is established or as soon as possible thereafter. The certification must be complete prior to when an HHA bills Medicare for reimbursement.

Certification Requirements: Who Can Perform a Face-to-Face Encounter

According to 42 CFR 424.22(a)(1)(v)(A), the face-to-face encounter can be performed by:

- The certifying physician;
- The physician who cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health);
- A nurse practitioner or a clinical nurse specialist who is working in collaboration with the certifying physician or the acute/post-acute care physician; or
- A certified nurse midwife or physician assistant under the supervision of the certifying physician or the acute/post-acute care physician.

According to 42 CFR 424.22(d)(2), the face-to-face encounter cannot be performed by any physician or allowed NPP (listed above) who has a financial relationship with the HHA.

Certification Requirements: Management and Evaluation Narrative

According to 42 CFR 424.22(a)(1)(i) if a patient's underlying condition or complication requires a Registered Nurse (RN) to ensure that essential **non-skilled** care is achieving its purpose and a RN needs to be involved in the development, management and evaluation of a patient's care plan, the physician will include a brief narrative describing the clinical justification of this need.

If the narrative is part of the certification form then the narrative must be located immediately prior to the physician's signature. If the narrative exists as an addendum to the certification form in addition to the physician's signature on the certification form, the physician must sign immediately following the narrative in the addendum.

For skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of a registered nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.

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For more information about SN for management and evaluation refer to Section 40.1.2.2, Chapter 7 of the "Medicare Benefit Policy Manual" at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf** on the CMS website.

Certification Requirements: Supporting Documentation

- Documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) shall be used as the basis for certification of home health eligibility. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.
- According to the regulations at 42 CFR 424.22(c), Certifying physicians and acute/post-acute care facilities must provide, upon request, the medical record documentation that supports the certification of patient eligibility for the Medicare home health benefit to the home health agency, review entities, and/or CMS. Certifying physicians who show patterns of non-compliance with this requirement, including those physicians whose records are inadequate or incomplete for this purpose, may be subject to increased reviews, such as provider-specific probe reviews.
- Information from the HHA, such as the patient's comprehensive assessment, can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient.
    - Information from the HHA must be corroborated by other medical record entries and align with the time period in which services were rendered**.**
    - The certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification of patient eligibility (that is, agree with the material by signing and dating the entry).
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain information that **justifies the referral** for Medicare home health services. This includes documentation that substantiates the patient's:
    1. Need for the skilled services; and
    2. Homebound status.
- The certifying physician's and/or the acute/post-acute care facility's medical record for the patient must contain the **actual clinical note for the face-to-face encounter visit** that demonstrates that the encounter:
    1. Occurred within the required timeframe;
    2. Was related to the primary reason the patient requires home health services; and

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3. Was performed by an allowed provider type.

This information can be found most often in, but is not limited to, clinical and progress notes and discharge summaries.

Please review the following examples included at the end of this article:

1. Discharge Summary;
2. Progress Note;
3. Progress Note and Problem List; or
4. Discharge Summary and Comprehensive Assessment.

Recertification

At the end of the initial 60-day episode, a decision must be made as to whether or not to recertify the patient for a subsequent 60-day episode. According to the regulations at 424.22(b)(1) recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and unless there is a:

- Patient-elected transfer; or
- Discharge with goals met and/or no expectation of a return to home health care.

  (These situations trigger a new certification, rather than a recertification)

Medicare does not limit the number of continuous episodes of recertification for patients who continue to be eligible for the home health benefit.

Recertification Requirements:

1. Must be signed and dated by the physician who reviews the plan of care;
2. Indicate the continuing need for skilled services (the need for OT may be the basis for continuing services that were initiated because the individual needed SN, PT or SLP services); and
3. Estimate how much longer the skilled services will be required.

Physician Billing for /Certification/Recertification

Certifying/recertifying patient eligibility can include contacting the home health agency and reviewing of reports of patient status required by physicians to affirm the implementation of the plan of care that meets patient's needs.

1. Healthcare Common Procedure Coding System (HCPCS) code G0180 − Physician certification home health patient for Medicare-covered home health service under a home health plan of care (patient not present).
2. HCPCS code G0179 −Physician recertification home health patient for Medicare-covered home health services under a home health plan of care (patient not present)

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Physician claims for certification/recertification of eligibility for home health services (G0180 and G0179 respectively) are not considered to be for "Medicare-covered" home health services if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

Additional Information

If you have questions, please contact your MAC at their toll-free number. The number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work?

More information is available at the Medicare Home Health Agency website at **http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html** on the CMS website.

Attached are a number of examples that illustrate some of the key points of this article.**Seasonal Flu Vaccinations -** Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information on coverage and billing of the influenza vaccine and its administration, please visit MLN Matters® Article #MM8890, "Influenza Vaccine Payment Allowances - Annual Update for 2014-2015 Season" and MLN Matters® Article #SE1431, "2014-2015 Influenza (Flu) Resources for Health Care Professionals."

While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community. The HealthMap Vaccine Finder is a free online service where users can search for locations offering flu and other adult vaccines. If you provide vaccination services and would like to be included in the HealthMap Vaccine Finder database, register for an account to submit your information in the database. Also, visit the CDC Influenza (Flu) web page for the latest information on flu including the CDC 2014-2015 recommendations for the prevention and control of influenza.

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Example 1

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Date of Encounter

DOE, JANE	00000123	02-13-2014	02-17-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: John A. Doe, M.D.
Dictated By: John A. Doe, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Right knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Right knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
02/14/2014: Total Right knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mrs. Doe is a pleasant 60-year old female who has had a longstanding history of right knee arthritis. She has complained of right sided knee pain since January 2013. Since then, her ambulation has been limited by pain and she has pain at night that interrupts sleep. Pain medication, ibuprofen and hydrocodone, have been unsuccessful in relieving her pain for the last 6 months. Workup did show reduction in the right knee joint space. She initially failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension, Gout.

PAST SURGICAL HISTORY:
Hysterectomy.

Meets the requirements for documenting: (1) the need for skilled services; (2) the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Coumadin 4 mg daily; blood draw for INR ordered for 2/20/2014.

DISCHARGE CONDITION:
Upon discharge Mrs. Doe is stable status post right total knee replacement and has made good progress with her therapies and rehabilitation. Mrs. Doe is to be discharged to home with home health services, physical therapy and nursing visits, ordered. The patient is temporarily homebound secondary to status post total knee replacement and currently walker dependent with painful ambulation. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation or adverse events from the new Coumadin medical regimen.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of her son. Diet is regular. Activity, weight bear as tolerated right lower extremity. The patient prescribed Coumadin 4 mg a day as the INR was 1.9 on discharge with twice weekly lab checks. Resume home medications. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Doe in two weeks.

Transcribed by: A.M 02/17/2014
Electronically signed by: John A. Doe, M.D. 02/17/2014 17:52

Example 2

Progress Notes
Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:
1. Wound on left heel.

HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.

ROS:
General:
No weight change, no fever, no weakness, no fatigue.
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

Example 3 – Part 1 of 2

Progress Notes
Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

Provider: Jane Doe, M.D.
Date: 09/01/2014

Allowed provider type

Date of Encounter

Subjective:
CC:
Weakness
HPI:
Pt was hospitalized 2 weeks ago for pneumonia. He was treated with IV antibiotics for 5 days and discharged on oral antibiotics for 10 days. His caregiver is present with him for the visit. The patient reports that his appetite has been decreased since the hospitalization and he has noticed increasing weakness and difficulty walking. The patient has lost 2 lbs. since his last visit. He has stayed in bed for most of the time since his hospitalization. He used a wheelchair to move from the front of the office building to the exam room. The patient has not needed a wheel chair previously. The patient denies any fever, chills, cough, rhinorrhea, sore throat, ear pain, difficulty drinking liquids, nausea, vomiting or diarrhea.
ROS:
General:
2 lb weight change, positive for weakness, positive for fatigue.
Pulmonary: As per the HPI
Cardiology:
No chest pain, no palpitations, no dizziness, no shortness of breath.

Medical History: HTN; hyperlipidemia; Diabetes Mellitus

Medications: ASA 325 mg once a day, Diovan HCl 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day. Metformin 1000 mg once a day.

Allergies: NKDA

Objective:
Vitals: Temp 98.6, BP 120/80, HR 71, RR 12, Wt 200, Ht 5'9" pulse ox 99% on room air
Examination: The patient is awake and alert and in no acute distress. He is in a wheelchair. HEENT: Pupils do not react to light. Heart rate regular rate and rhythm, lungs clear, BS present, Extremities: pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees ; Muscle Strength 3/5 in all 4 extremities(normal 5/5). The patient's get up and go test was 35 seconds(normal <10)

Assessment:
1. Muscle Weakness secondary to deconditioning due to pneumonia

Plan:
1. Prior to the patient's hospitalization for pneumonia, the patient could ambulate in his residence with assistance and was able to rise from a chair without difficulty. The patient requires a home health PT program for gait training and increasing muscle strength to restore the patient's ability to walk in his residence.

Follow Up: Return office visit in 6 weeks.

Provider: Jane Doe, M.D.
Electronically signed by Jane Doe, M.D. on 09/02/2014 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see problem list (Part 2 of 2) for homebound status.

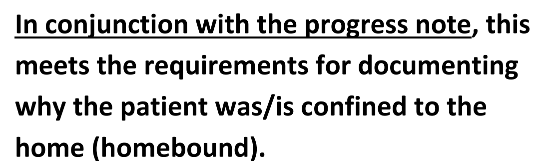
Example 3 – Part 2 of 2

Problem List*

Patient: Rogers, Buck
DOB: 08/13/1925
Address: 234 Happy Lane, Teamwork, MD 12345

401.1 HTN - 1999
272.2 Hyperlipidemia -1999
250.5 Diabetes Mellitus with ophthalmic manifestations -2000
369.22 Blindness - 2002 (requires caregiver assistance in order to leave the home)

482.31 Pneumonia- Streptococcus- 2014



***A problem list would not be acceptable by itself to demonstrate skilled need and/or homebound status.**

Example 4 – Part 1 of 2

Date of Encounter

AAA HOSPITAL DISCHARGE SUMMARY
-DEPARTMENT OF SURGERY-

Smith, John	00000124	04-14-2014	04-18-2014
Patient Name	Med Rec No.	Admit Date	Discharge Date

Physician: Sam Bone, M.D.
Dictated By: Sam Bone, M.D.

Allowed Provider Type

ADMISSION DIAGNOSIS:
Left knee osteoarthritis.

DISCHARGE DIAGNOSIS:
Left knee osteoarthritis.

CONSULTATIONS:
1. Physical Therapy
2. Occupational Therapy

PROCEDURES:
04/14/2014: Left knee arthroplasty.

HISTORY OF PRESENT ILLNESS:
Mr. Smith is 70 y.o. male who presents with left knee osteoarthritis for 10 years. Over the past three years the pain has steadily increased. It was initially controlled by ibuprofen and steroid injections. In the last year he has required ibuprofen and Percocet to ambulate and this treatment has been unsuccessful in relieving pain for the last 6 months. His ambulation has been limited by pain and he has pain at night that interrupts sleep. Workup did show reduction in the left knee joint space. He has failed conservative treatment and has elected to proceed with surgical treatment.

PAST MEDICAL HISTORY:
Hypertension

PAST SURGICAL HISTORY:
Inguinal hernia repair

Meets the requirements for documenting: (1) the need for skilled services; and (2) that the encounter was related to the primary reason the patient requires home health services.

Please see OASIS (Part 2 of 2) for homebound status.

DISCHARGE MEDICATIONS:
Colace 100 mg daily, Percocet 5/325 every 4 hours as needed for pain, Lisinopril 10 mg daily, Lovenox 30mg sq every 12hours for 6 more days.

DISCHARGE CONDITION:
Upon discharge Mr. Smith is stable status post left total knee replacement and has made good progress with his therapies and rehabilitation. Mr. Smith is to be discharged to home with home health services, physical therapy and nursing visits, ordered. PT is needed to restore the ability to walk without support. Short-term skilled nursing is needed to monitor for signs of decompensation and teaching of Lovenox injections.

PATIENT INSTRUCTION:
The patient is discharged to home in the care of his wife. Diet is regular. Activity, weight bear as tolerated left lower extremity. Call the office or return to the emergency room for any concerns including increased redness, swelling, drainage, fever, or any concerns regarding operation or site of incision. The patient is to follow up with Dr. Bone in two weeks.
Transcribed by: A.M 04/18/2014
Electronically signed by: Sam Bone, M.D. 04/18/2014 18:31

Generic Home Health Agency
Excerpt from Comprehensive Assessment (OASIS-C)

Patient Name: John Smith
HH Record Number: 4433225

ADL/IADLs continued

(M1845) Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

☐ 0 - Able to manage toileting hygiene and clothing management without assistance.

X 1 - Able to manage toileting hygiene and clothing management without assistance if supplies/implements are laid out for the patient.

☐ 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.

☐ 3 - Patient depends entirely upon another person to maintain toileting hygiene.

Comments: *Patient requires clothes to be laid out on bed. He is able to dress himself from a seated position at foot of bed.*

(M1850) Transferring: Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

☐ 0 - Able to independently transfer.

X 1 - Able to transfer with minimal human assistance or with use of an assistive device.

☐ 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.

☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.

☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.

Comments: *Patient requires one-arm assistance to transfer from bed to chair.*

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

☐ 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).

☐ 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.

X 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.

☐ 3 - Able to walk only with the supervision or assistance of another person at all times.

☐ 4 - Chairfast, unable to ambulate but is able to wheel self independently.

☐ 5 - Chairfast, unable to ambulate and is unable to wheel self.

☐ 6 - Bedfast, unable to ambulate or be up in a chair.

Comments: *Pt. with a shuffling gait and frequently trips while ambulating. Pt. requires a wheeled walker and requires frequent cueing to remind him to not shuffle when he walks and to look up to avoid environmental hazards. Unable to go up and down stairs without his daughter assisting him. Daughter states that patient needs 24/7 supervision and is only able to leave his home for doctor appointments and only when she and her husband assist him. Patient is an increased fall risk because of inability to safely navigate stairs, uneven sidewalks and curbs.*

In conjunction with the discharge summary, this meets the requirements for documenting why the patient was/is confined to the home (homebound).

Sam Bone, M.D. 4/20/2014

Signed and dated by certifying physician indicating review and incorporation into the patient's medical record.