Responding to Home Health Additional Documentation Request (ADR) Checklist

This checklist is provided as a reminder of what to include when responding to an ADR

Plan of Care and Certification/Recertification

- ☐ Signed and dated prior to billing the end of episode claim
- ☐ Physician orders not included on the Plan of Care must be signed and dated prior to billing the final claim to Medicare
- ☐ Signature log or attestation of signature if illegible
- ☐ Initial (start of care) certification and plan of care regardless of dates of service billed
- ☐ For subsequent episodes, include the recertification and plan of care for the dates of service being reviewed (in addition to the initial certification and plan of care).

Signatures

- ☐ If you question the legibility of any signed document, submit a signature log or an attestation statement for that signature.
- ☐ If electronic signatures are used, submit documentation to verify that the entries are appropriately authenticated, dated, system safeguards are in place to prevent unauthorized access, and there is a process in place for reconstruction.

OASIS

- ☐ OASIS assessment used to generate HIPPS code billed during this period must be present in the national repository

Face to Face Encounter

- ☐ Include clinical findings to support the need for skilled services
- ☐ Include documentation to support homebound status
- ☐ Submit face to face encounter documentation for the dates of service under review. This should be included for all responses whether the claim is a start of care claim or a subsequent episode. Ensure the documentation of clinical findings as well as the signature and date of encounter is legible.
- ☐ Any information that was created/generated by the home health agency, sent to the physician and is now incorporated in the physician held medical record, may be submitted if signed off by the certifying physician and/or acute/post-acute care facility

Documentation of services rendered

- Documentation to determine medical necessity of all services billed and to support the Health Insurance Prospective Payment System (HIPPS) code (or level of payment) billed
- In/out time for nurse and aide visits
- If nurse visits are daily, submit a statement of endpoint that indicates when nurse visits are expected to decrease to less than seven days a week.
- If a patient's sole skilled service need is for skilled oversight of unskilled services (Management and Evaluation of the care plan), submit the physician's brief narrative describing the clinical justification of the need for services. This statement can be part of the certification or recertification, or as a signed addendum to the certification or recertification.
- Documentation for all PRN (as needed) visits, including dates, reason for the PRN visits, outcome of visits and orders for services must be included.
- Any other pertinent documentation that may be needed to establish medical necessity (e.g., date of hospitalization, medication changes, laboratory values, physician contacts/visits, etc.).
- Documentation to support each visit billed
- All supplemental orders to cover billed services
- Initial therapy (PT,OT,SLP) evaluation regardless of dates of service billed
- Therapy (PT,OT,SLP) re-assessment/re-evaluations for prior billing period and for dates of service in question
- Therapy documentation requirements as follows: assessment, measurement and documentation of therapy effectiveness; initial therapy assessment; reassessment at least every 30 days (performed in conjunction with an ordered therapy service); and for dates of service prior to 01/01/15, include the reassessment prior to the 14th and 20th therapy visit.
- Submit documentation denoting treatment week**,** when different from calendar week.
- Submit Advance Beneficiary Notice (ABN) if applicable
- Submit all documentation as required in the LCD or NCD if applicable