✓	*Item to review:*
	General Consent & Notices: All sections appropriately completed **Intake/Referral Form**: Complete/dated/signed by person taking any verbal orders.
	SOC Verbal Order: ▪ Complete/appropriately documented ▪ SOC date = 1st billable visit
	Case Conference: Documentation of MCP/clinical associate case conference.
	Care Protocols: Care Protocol is selected to correlate with primary diagnosis. Other protocols may be used in addition as appropriate. If variance protocol is selected reason is documented.
	Personal Care Plan: ▪ Frequency of personal Care Tasks. ▪ Safety Issues and Functional Limitations ▪ Code Status ▪ Vital sign parameters and s/s to report
	Diagnoses: ▪ Diagnoses are appropriate for services provided and coded accurately. ▪ Diagnoses support additional services ▪ Diagnoses are ordered to reflect home care needs (Primary diagnosis should be driven by the illness or condition that will require the most intensive services) ▪ If V code is used as primary diagnosis—M1024 should be completed as appropriate. ▪ Onset/Exacerbation dates should be realistic related to this home care episode. ▪ **NOTE:** If any changes are made in M1020 and M1022 of the OASIS file the codes must also be updated in F4 of the patient master file.
	Surgical Diagnoses: Included when appropriate for this home care episode.
	Medication Profile: ▪ Dose, route, frequency and drug class. ▪ N or C is indicated. ▪ Therapy admits are reviewed for contradictions.
	MEV Complete and Issues resolved

	OASIS REVIEW
	OASIS Summary Screen: ▪ This screen gives a summary of the responses to the OASIS questions that impact the HHRG for this patient. Check for OASIS questions that correspond with patient's primary and secondary diagnoses. For example, M1400 answer for a patient with a diagnosis of COPD. Ensure a comprehensive assessment has been documented for these areas. ▪ Check for completion of M1024 as appropriate. ▪ Check the functional status of the patient to verify: o M1810 through M1860 correlates with patient's overall status and supports homebound status. o Responses are consistent with the therapy evaluation(s). Support additional services ordered. ▪ Verify M2200 accuracy with therapy evaluation(s). M2200 must be a numerical value. Verify total number of therapy visits to be done is correct (PT, OT, ST)
	Wound Assessment (M1300 – M1350): Needs to match the diagnosis coding of the wounds. Verify accuracy of wound related answers as this will affect supply reimbursement.
	F9 Edit Check: Correct or Complete any missing and/or incorrect OASIS items
	OASIS Alerts Report: Review for errors or inconsistencies in the assessment. Compare, confirm, clarify, correct OASIS information as necessary.
	POT REVIEW: Review all areas
	Medications: ▪ Review for accuracy, new or changed status. ▪ If the patient is on Oxygen it must be on the medication list. ▪ If the patient is on IV therapy then all IV drugs must be included as well as Saline and Heparin flushes.
	DME and Supplies: List those being provided during the home care episode.
	Safety Measures: Need to be patient specific
	Nutritional Requirements: List specific diet
	Allergies: Check referral information for allergy information
	Functional Limitations: Be sure they correlate with the following OASIS questions: ▪ M1200 vision (box 1 or 2 checked) ▪ M1242 pain (box 2 or 3 checked) ▪ M1400 dyspnea (box 2, 3, or 4 checked) ▪ M1615 urinary incontinence ▪ M1620 bowel incontinence ▪ Other functional ADL questions: M1810, 1820, 1830, 1840, 1845, 1850, 1860 **Homebound Status:** Can be viewed at "other" field of Functional Limitations. Must be specific to this patient and be supported by functional limitations

	Activities Permitted: Needs to be appropriate based upon the assessment documented.
	Mental Status/Prognosis: Mental status needs to correlate with M1740 cognitive, behavioral, and psychiatric symptoms.
	Frequency and Duration: ▪ Each discipline ordered on referral should have frequency and duration ▪ Should correlate with care protocol chosen at start of care
	Orders for Disciplines and Treatment: ▪ Assessment, treatment and teaching orders relate to diagnoses and the condition of the patient. ▪ If wound care is ordered: does it include specific location, frequency and supplies used? Do they include caregiver/family involvement in dressing changes? Is the wound care complex, requiring the skills of a nurse? ○ If more than one wound exists, specify the above for each.
	Goals/Rehab Potential/Discharge Plans ▪ Appropriate for diagnoses, orders and rehab potential ▪ Measurable and include dates ▪ Finite and predictable end point for daily SN visits if ordered daily for more than 21 days (except for administration of insulin when the patient is unable to self administer)