Harmony Healthcare INTERNATIONAL

HELP LETTER REVIEW CHECK LIST

Period Skilled Nursing Chart Review: From: __________________ To: __________________

Medicare Admission Date: ___________ Diagnosis: ________________________________

MDS Reference Dates Review

	5 day	14 day	30 day	60 day	90 day	SOT/EOT OMRA
ARD						
Billing Dates						
RUG/HIPPS						

	COT	COT	COT	COT	COT	COT
ARD						
Billing Dates						
RUG/HIPPS						

ICD-10 Codes

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MDS Forms Completed Since Admission

- ❑ MDSs that cover days billed
- ❑ ARDs set in acceptable time frames
- ❑ Signed by all disciplines
- ❑ Interviews are signed on day interview completed
- ❑ Signed by RN Coordinator
- ❑ Documentation to support Rehabilitation RUG in Section O
- ❑ Documentation to support coding IVs in Section K & O (from hospital if applicable)
- ❑ Documentation to support ADL coding in Section G
- ❑ RUG rate matches billed rate on UB-04
- ❑ Z0500B within 14 days of ARD
- ❑ OMRAs completed when necessary and within appropriate time frames
- ❑ Interviews completed, not dash-filled
- ❑ Documentation present to support diagnoses coded in Section I
- ❑ Documentation present to support Shortness of Breath in Section J

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Physician Certification

- ❑ Signed on admit
- ❑ Recertification signed by day 14 and every 30 days after for entire billing period
- ❑ Details regarding skilled Nursing services present
- ❑ Details regarding skilled Therapy services present

Physician Orders for Review Period

- ❑ Monthly orders signed by physician
- ❑ Interim orders signed by physician
- ❑ Telephone orders signed by physician
- ❑ Therapy evaluation orders present and signed
- ❑ Therapy clarification orders present and signed
- ❑ Therapy recertifications present and signed

Acute Discharge Summary/ Acute and Facility History and Physical

- ❑ Three day qualifying stay verified
- ❑ Discharge Summary
- ❑ Hospital and Facility H&P

Physician Progress Notes

- ❑ Admission note
- ❑ MD progress note at least every 30 days

Nursing Notes

- ❑ Admission note
- ❑ Daily skilled Nursing notes present for entire period under review
- ❑ Daily skilled Nursing notes present for MDS look-back periods
- ❑ Daily notes 30 days prior to ARD date of any MDS billed
- ❑ Documentation to support daily skills listed on MD Certification
- ❑ Weekly Medicare meeting summaries
- ❑ Documentation to support staff coding of PHQ-9-OV

Medication/ Treatment Records

- ❑ MARs present for MDS look-back periods
- ❑ TARs present for MDS look-back periods
- ❑ Minutes on Respiratory Therapy and or nursing treatment sheets match each MDS in billing period
- ❑ Wound flowsheets completed in full and present for each MDS in billing period

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Parenteral/ Enteral Intake Records to Support Amount Received

- ❑ Dietician notes for G/J Tube
- ❑ Treatment or Medication Records
- ❑ Input and Output if applicable

ADL Flowsheets

- ❑ Flowsheets present for all MDS look-back periods
- ❑ All dates have been filled in
- ❑ All signatures present
- ❑ Corrections included

Rehabilitation - For Review Period and 7 days prior to ARD of any MDS billed.

- ❑ Evaluation signed timely by physician (always include initial evaluation with all review periods) for each discipline provided in ARD and Review period
- ❑ Updated Monthly Progress Note for each discipline provided in ARD and Review period
- ❑ Weekly Progress Notes present and support ongoing skilled services (present for entire period in Review)
- ❑ Billing logs for entire period in review
- ❑ Billing logs for ARD look-back periods
- ❑ Minutes and days on therapy logs match Section O
- ❑ Daily documentation supports minutes on billing logs
- ❑ Daily Notes for each discipline provided in ARD and Review period
- ❑ Daily Notes support clinically justification for co-treatment
- ❑ Co-treatment minutes supported by both disciplines
- ❑ Co-treatment minutes on billing logs, Daily Notes, and Section all match
- ❑ Any additional documentation to support functional progress (standardized testing, etc.)

Restorative Nursing Documentation

- ❑ Plan of care
- ❑ Daily log
- ❑ Progress notes at least every 30 days
- ❑ Physician orders

Diagnostic Reports (labs, x-ray)

- ❑ Include for review period

Trach and Vent Documentation

- ❑ Documentation to support trach care

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Other documents to support skilled level of care (review billed RUG and include only if needed to support skill/RUG billed).

- ❑ BEHAVIOR: Behavior sheets, Social Service Notes and Psych Documentation
- ❑ Reduce Physical Functioning: Dietary, possibly detailed care plan to support aggregate of services
- ❑ Nursing teaching sheets to family and patient
- ❑ Consult reports

Denial Notification if remained in facility and Medicare discontinued at end of review period

- ❑ Signed by patient or guardian
- ❑ Check to have Medicare review or decline review

Signature Log

- ❑ Signature Log included for all staff members

The following items must be added to this record prior to submitting:

1.	5.
2.	6.
3.	7.
4.	8.

Comments/Risk Areas:

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DON: ________ MDSC:________ Rehab:__________ Regional/Consultant : __________

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