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HOME HEALTH

# Clinical Record Integrity in Home Health

## Documentation in an Era of Heightened Oversight

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# Learning Objectives

- Describe the Medicare Conditions of Participation requirements related to accurate, complete, timely, accessible, and properly authenticated clinical records.
- Identify common clinical documentation integrity issues cited during home health audits, medical reviews, investigations, and surveys.
- Differentiate between high-risk documentation practices and defensible, patient-specific documentation that supports medical necessity, skilled need, and homebound status.
- Explain how inconsistent, cloned, untimely, or incomplete documentation may increase regulatory, financial, legal, and fraud-risk exposure for home health agencies.
- Apply practical compliance, auditing, QAPI, and staff education strategies to strengthen documentation integrity and improve audit defensibility in home health operations.

# Current Oversight Environment in Home Health

- The current oversight environment is:
- Prevention-focused, data-driven, and enforcement-oriented.
- CMS and federal partners are no longer only recovering improper payments after the fact but are implementing methods to identify and stop suspected fraud earlier.
  - *enrollment moratoria, advanced analytics, payment suspensions, targeted investigations, revocations, and criminal enforcement partnerships*

# Current Oversight Environment in Home Health

- **CMS 6-month nationwide Medicare enrollment moratorium** [6]
  - During the moratorium, CMS says it will intensify targeted investigations, use advanced data analytics, and accelerate removal of HHA providers suspected of fraud.
- **CMS "Crushing Fraud, Waste, & Abuse" initiative** [7]
  - In March 2025, CMS launched the Fraud Defense Operations Center (FDOC), better known as the Fraud War Room.
- **Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH)** [7]
  - Introduced in February of 2026

# Current Oversight Environment in Home Health

- **West Coast Health Care Fraud Strike Force** [10]
  - Launched by DOJ in April 2026 for Arizona, Nevada, and Northern California, using data-driven prosecution and coordination with HHS-OIG, FBI, DEA, and U.S. Attorneys.
  - Not limited to home health, this is part of the broader health care fraud enforcement environment affecting Medicare and Medicaid providers

- **HHS-OIG Work Plan** and **National Health Care Fraud Takedown activity** [11]
- **Post-payment review by the Supplemental Medical Review Contractor (SMRC)/Noridian Solutions-Project 01-158** [9]
  - a new post-payment review targeting Medicare Part A home health services provided for 361 days or longer.
  - the claim type and dates of service in this project are January 1, 2024 through December 31, 2024 for Type of Bill (TOB) 032X.

- **Boots-On-The- Ground Initiative** [7]

# Current Oversight Environment in Home Health

Recent outcomes:

- Across Q1 2026, CMS issued over **200 Medicare payment suspensions** on high-risk hospice and home health providers in **California**. Payments are paused while CMS investigates concerning billing behavior. [6.7]
- CMS **revoked 1,413 providers and suppliers**, a **40% increase** in the number of revocations since the same quarter in 2025. [6.7]
- Total Medicare program integrity savings surged **59%, from $26.3 billion in FY 2024** to a record-shattering **$41.9 billion in FY 2025**. The FY 2025 Medicare Return on Investment (ROI) reached $22.3 to 1, up from $14.6 to 1, the highest ROI ever. [6.7]

# Crushing Fraud | Q1 2026

## OVERPAYMENTS

**Overpayments Identified**
through medical review
**$850 million**

**Overpayments Identified**
through medical review
**651 providers**

**Overpayments Collected**
through post-payment review
**$216 million**

## PAYMENT SUSPENSIONS

**$187**
million

**327**
providers & suppliers

## CLAIM DENIALS

**27,355**
claims denied for failing to meet Medicare FFS requirements

Source: https://www.cms.gov/files/document/cpi-quarterly-dashboard.pdf

# What Can Home Health Providers Do to Stay Protected?

- During audits, investigations, and medical reviews, the reviewer does not see the patient — they see the **documentation**.
- **Documentation integrity** has become one of the most critical compliance and risk-management priorities in home health, directly impacting survey outcomes, payment integrity, audit defensibility, and allegations of fraud, waste, and abuse.
- **Strong documentation integrity** helps agencies demonstrate not only that services were provided, but that they were medically necessary, properly coordinated, timely, accurate, and compliant with Medicare requirements.

# Documentation Integrity

## CMS Conditions of Participation [8]

- 42 CFR §484.110 requires home health agencies to maintain clinical records that are:
  - Accurate
  - Complete
  - Timely
  - Accessible
  - Properly authenticated

# Documentation Integrity

| Clinical Record Component | Examples of Documentation Included | Why It Matters |
|---|---|---|
| **Referral & Intake Documentation** | Referral/order for services, intake information, insurance verification, hospital discharge paperwork, face-to-face encounter documentation | Establishes eligibility, physician involvement, and reason for home health admission |
| **Comprehensive Assessment Documentation** | Start of Care (SOC) assessment, OASIS, nursing assessment, therapy evaluations, risk assessments | Supports homebound status, skilled need, and medical necessity |
| **Physician Orders & Certification Documentation** | Signed Plan of Care (POC/485), certification/recertification, verbal orders, supplemental orders, treatment orders | Demonstrates physician authorization and directs care provided |
| **Visit Documentation** | Skilled nursing notes, therapy notes, aide notes, supervisory visits, care coordination documentation | Supports services billed, skilled interventions, and patient response |
| **Medication & Treatment Documentation** | Medication profile, medication reconciliation, allergy list, wound care documentation, IV therapy documentation | Supports patient safety, treatment accuracy, and compliance |
| **Ongoing Care Management Documentation** | Recertification assessments, transfer/resumption of care documentation, updated goals/interventions | Demonstrates continued medical necessity and progression of care |
| **Communication & Coordination Documentation** | Physician communication, caregiver communication, interdisciplinary coordination, patient education | Supports continuity of care and coordination of services |
| **Discharge Documentation** | Discharge summary, discharge OASIS, patient status at discharge, instructions, physician notification | Demonstrates outcomes, completion of services, and discharge planning |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Accuracy** | Under the Medicare CoP (42 CFR §484.110) [8], home health agencies must maintain clinical records that are accurate and appropriately reflect the patient's condition, assessment findings, services provided, clinical judgment, and patient response at the time care was delivered. | OASIS indicates patient ambulates independently, while nursing documentation states patient requires extensive assistance and walker for ambulation. | OASIS, therapy evaluation, and nursing notes consistently document patient requiring walker and caregiver assistance due to weakness and fall risk. |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Consistency** | Under the Medicare CoPs (42 CFR §§484.60 and 484.110) [8], documentation throughout the clinical record should consistently align across disciplines, OASIS assessments, physician orders, visit notes, care plans, and medication profiles without contradictions or unexplained discrepancies. | Nursing documentation states patient is homebound due to severe weakness and dyspnea with minimal exertion, while another visit note documents patient independently driving to the grocery store several times weekly without difficulty. | Patient remains homebound secondary to severe generalized weakness, impaired endurance, and dyspnea with minimal exertion related to CHF and chronic respiratory disease. Patient requires frequent rest periods with ambulation greater than 15–20 feet and utilizes walker for mobility within home. |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Completeness** | Under the Medicare CoPs(42 CFR §484.110), clinical records must contain complete documentation necessary to support the patient's condition, physician involvement, skilled services provided, medical necessity, care coordination, and compliance with regulatory and payer requirements.<br><br>All areas/sections of the documents/forms are fully completed, no blanks left | Skilled nursing visit note states "wound care performed" but does not include wound assessment, measurements, drainage, patient response, or dressing applied. | Skilled nursing note includes wound location, measurements, tissue description, drainage, odor, pain assessment, wound care provided, patient tolerance, and physician notification when appropriate. |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Timeliness** | Under the CoPs(42 CFR §484.110) [8], clinical records must be completed, authenticated, and incorporated into the patient record timely to support continuity of care, patient safety, physician communication, and the credibility of the clinical record.<br><br>Documentation is completed and authenticated, within required regulatory, payer, and agency-established timeframes to support continuity of care, clinical decision-making, and record credibility. | Skilled nursing visit performed on Monday but documentation completed three weeks later after clinician unable to recall visit details accurately. | Skilled nursing visit completed and authenticated within agency-required timeframe with timely documentation of assessment findings, interventions, patient response, and physician communication. |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Accessibility** | Under the Medicare CoPs (42 CFR §484.110) [8], clinical records must be maintained in a manner that makes them accessible, organized, retrievable, and available to authorized personnel for patient care, coordination of services, audits, surveys, investigations, and regulatory review. | Agency unable to provide signed physician orders, visit notes, and recertification documentation during ADR review because records were incomplete or not retrievable timely. | Agency maintains organized and secure clinical records with timely retrieval of physician orders, OASIS assessments, visit notes, medication profiles, and care coordination documentation during audit and survey review. |

# Documentation Integrity

| | Definition | Audit Risk Example | Defensible Documentation Example |
|---|---|---|---|
| **Proper Authentication** | Under the Medicare CoP (42 CFR §484.110)[8], clinical records must be properly authenticated, meaning documentation must include appropriate signatures, credentials, dates, and author identification to verify who provided, reviewed, approved, or documented the care and when the documentation was completed.<br>○ If electronic signature is utilized, compliance with requirements must be ensured | Recertification order present in chart but missing physician signature and date; skilled nursing visit note completed without clinician credentials. | Physician orders and recertification documentation signed and dated by authorized provider; visit notes include clinician signature, credentials, and date/time of documentation completion in accordance with agency policy and regulatory requirements. |

# Where Documentation Integrity Issues Arise

- Internal audits
  - Routine QA chart review and pre-billing checks
- MAC reviews
  - Medical necessity and coverage support
- UPIC investigations
  - Potential fraud, waste, and abuse patterns
- OIG reviews
  - Systemic compliance vulnerabilities
- Surveys
  - CoPs, clinical record management, care planning

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Weak evidence of skilled services/medical necessity
  - Skilled nursing services not supported as medically necessary.
    - General assessment only
    - Medication planner prefill/management
- Skilled nurse notes indicate repetitive teaching without clear description of patient understanding of teaching.
- Documentation does not support why beneficiary cannot self-inject medication or why there is not a willing/able caregiver available.[12]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Weak evidence of skilled services/medical necessity
  - Therapy services not supported as skilled
    - Documentation does not support that therapy services:
      - Are reasonable and necessary
      - Require the skills of a qualified therapist
      - Are at a level of complexity requiring professional therapy intervention[13]
- Why this matters
  - High denial risk during medical review
  - Weak support for Medicare coverage criteria
  - Frequent target area for UPIC/MAC review

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Copy-Paste/Cloned Documentation
  - Repeated or cutting/pasting nursing or therapy documentation
  - Identical narratives across different dates
  - Same vitals, assessments, and interventions repeatedly
  - EMR cloning without individualized updates[4,5]
- Reviewer concerns:
  - Services may not have reasonable or necessary
  - Suggests the visit may not have been performed or patient not assessed
  - Lack of individualized care
  - Potential fraud/abuse concerns
  - Credibility of the clinical record is weakened.

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Copy-Paste/Cloned Documentation
  - Risks of erroneous and incomplete documentation
    - Improper documentation also can contribute to adverse, sometimes fatal, patient outcomes.
    - Disciplinary actions from state boards of nursing may be imposed on a nurse in the event of negative patient outcomes resulting from erroneous or missing documentation.
    - Failure to provide accurate and complete documentation puts you at risk of being named in a malpractice lawsuit.[2]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Copy-Paste/Cloned Documentation
  - According to liability claim reports published by the insurance provider Coverys in 2021 and the Nurses Service Organization (NSO) in 2020, omissions or errors in nursing documentation were responsible for 72% of all EHR-related risk issues, and the second highest reason for liability claims against nurses. NSO's analysis of the specific types of allegations related to nursing documentation revealed the following:
    - 50% are due to fraudulent or falsified patient records[2]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Over-reliance on standardized EMR templates, “canned” interventions, and generic goals
  - Notes sound identical across multiple patients
  - Interventions do not reflect the patient’s actual condition or needs
  - Goals are not individualized to the patient’s diagnosis, deficits, or functional status
- Generic interventions fail to explain:
  - Why skilled services are required
  - Why the patient cannot self-manage
  - Why ongoing skilled care remains necessary

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Over-reliance on standardized EMR templates, “canned” interventions, and generic goals
  - Goals that are not measurable
    - Goals lack:
      - Timeframes
      - Objective measurements
      - Functional outcomes
- Interventions not aligned with POC
  - Visit notes do not support interventions listed in the EMR-generated POC that is not individualized.
  - Generic EMR selected interventions may remain on POC even when no longer clinically relevant

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Certification / Face-to-Face / Order Deficiencies
  - Face-to-face encounter date missing from certification and POC
  - Signatures missing from recertification orders
  - No documentation that physician approved the plan of care[12, 13]
- Risks:
  - Claim denial
  - Invalid certification period
  - Survey deficiencies
  - Increased audit scrutiny

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Untimely documentation
  - Agency policy states documentation completion within 48 hours
  - PT visit notes completed
    - 7 days later
    - Several weeks later
    - Up to one month later[1]
- Why this matters:
  - Impacts record credibility
  - Raises concerns regarding accuracy of documentation
  - Weakens continuity of care

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Incomplete clinical documentation
  - Clinical notes missing credentials (RN, LVN/LPN, PT, etc.)
  - Visit notes do not document patient response to treatment
  - Missing signatures on recertification orders[1]
- Medication Profile Deficiencies
  - No indication for PRN medications
  - Oxygen not included on medication profile
  - Allergies or “NKDA” missing[1]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Medication Profile Deficiencies
  - IV medications missing:
    - Diluent
    - Total volume
    - Rate
    - Method of infusion[1]
- Incomplete skilled orders:
  - Catheter change orders missing:
    - Catheter size
    - Balloon size
    - Catheter type
    - Next catheter change due date[1]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- POC inconsistencies and inaccuracies
  - POC does not match patient condition
    - Referral indicates SN/PT/OT ordered but POC includes SN only
    - Goals inconsistent with assessment findings:
      - Medication management goal despite patient being independent at admission
      - Pain goals despite documentation indicating pain is not a problem[1]
- Orders not relevant to patient condition
  - Blood glucose parameters ordered despite:
    - No diabetes diagnosis
    - No diabetic medications
  - Interventions not related to patient medical status[1]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- POC inconsistencies and inaccuracies
  - Missing Discipline-Specific Care Planning
    - Home health aide frequency present
    - No aide goals or interventions included
  - OASIS/Assessment Inconsistencies
    - OASIS indicates PT involvement
    - No PT orders or assigned therapist documented[1]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Failure to Follow Physician Orders / POC
  - Ordered Interventions Not Performed or Documented
    - Orders require medication reconciliation every visit
      - Visit notes do not reflect completion
  - POC requires blood sugar monitoring
    - No blood sugar documentation in SN visit notes
  - Weekly weights ordered
    - Weights not consistently documented
    - Significant weight change not reported to physician[1]

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Supervision and oversight deficiencies
  - No evidence RN supervised LVN at least every 60 days[1]
- Risks:
  - State survey deficiencies
  - Personnel oversight concerns
  - Clinical quality concerns

# Common Issues Identified During Audits, Medical Reviews, and Surveys

- Documentation accuracy and integrity issues
  - Inaccurate documentation
  - OASIS indicates therapy involvement without supporting orders
  - Documentation conflicts across record
- Improper Documentation Practices
  - Improper medical abbreviations used contrary to agency policy
- Why This Matters
  - Raises integrity concerns
  - Weakens reliability of record
  - Increases legal and survey risk

# Documentation Examples: Audit Risks vs. Best Practice

- Generic goal: “Patient will be independent with medication management.”
- Problems:
  - Not measurable
  - No timeframe
  - No patient-specific barriers identified
  - Does not support skilled need
- Improved patient-specific goal: “Patient/caregiver will accurately identify the purpose, dose, schedule, and major side effects of all high-risk medications with 100% accuracy within the certification period to reduce risk of medication-related hospitalization.”

# Documentation Examples: Audit Risks vs. Best Practice

- Generic intervention: “Medication teaching provided.”
- Problems:
  - No skilled detail
  - No teaching topic identified
  - No patient response documented
  - Appears repetitive across visits
- Improved patient-specific intervention: “SN instructed patient and daughter on insulin administration technique, recognition of hypoglycemia symptoms, and proper timing of insulin in relation to meals due to recent episodes of blood glucose instability. Patient required repeated cueing due to memory deficits and remains unable to independently manage insulin regimen safely.”

# Documentation Examples: Audit Risks vs. Best Practice

- Generic intervention: “Wound care performed per order.”
- Problems:
  - No assessment findings
  - No skilled judgment
  - No patient response
- Improved patient-specific intervention:
  - Wound description: Stage 3 pressure ulcer on sacrum, 3.2cm x 2.8cm x 1.5cm. Wound bed is 80% red granulation tissue, 20% yellow slough at 3 o’clock position. Undermining of 1.5cm noted from 12 to 2 o’clock. Moderate serosanguinous drainage with no odor.
  - Wound care provided as follows: SN cleansed wound with wound cleanser, applied calcium alginate to wound bed and covered with foam border dressing. Patient reports pain at 2/10 during dressing change, a decrease from 5/10 in previous dressing change.

# Documentation Examples: Audit Risks vs. Best Practice

- Generic goal: “Patient will understand CHF.”
- Problems:
  - Not measurable
  - No functional outcome
  - No timeframe
- Improved patient-specific goal: “Patient/caregiver will verbalize understanding of CHF exacerbation symptoms, daily weight monitoring parameters, and when to notify physician by end of certification period to reduce risk of hospitalization.”

# Documentation Examples: Audit Risks vs. Best Practice

- Cloned skilled visit documentation by 3 different nurses
  - **Visit 1**
    - “Patient alert and oriented. Vital signs stable. Medications reviewed. Teaching provided regarding CHF management and low sodium diet. Patient verbalized understanding. No distress noted. Continue plan of care.”
  - **Visit 2**
    - “Patient alert and oriented. Vital signs stable. Medications reviewed. Teaching provided regarding CHF management and low sodium diet. Patient verbalized understanding. No distress noted. Continue plan of care.”
  - **Visit 3**
    - “Patient alert and oriented. Vital signs stable. Medications reviewed. Teaching provided regarding CHF management and low sodium diet. Patient verbalized understanding. No distress noted. Continue plan of care.”

# Documentation Examples: Audit Risks vs. Best Practice

- Improved patient-specific documentation
  - **Visit 1**
    - “SN assessed cardiopulmonary status due to CHF diagnosis and recent hospitalization for fluid overload. Mild bilateral lower extremity edema noted with weight increase of 2 lbs since previous assessment. SN instructed patient on importance of daily weight monitoring and sodium restriction. Patient demonstrated partial understanding and caregiver instructed on reading nutrition labels.”
  - **Visit 2**
    - “SN reassessed CHF symptoms. Weight stable since prior visit; however, patient reports increased shortness of breath with ambulation to bathroom. Oxygen saturation decreased to 90% after exertion and recovered to 94% at rest. SN reinforced energy conservation techniques and instructed caregiver to notify physician of worsening dyspnea or rapid weight gain.”

# Documentation Examples: Audit Risks vs. Best Practice

- Improved patient-specific documentation
  - **Visit 3**
    - “SN evaluated response to CHF interventions. Patient demonstrated improved understanding of low sodium dietary restrictions and accurately verbalized when to report weight gain to physician. Trace edema remains present but no new respiratory distress observed. Continued skilled nursing indicated for ongoing cardiopulmonary assessment and reinforcement of CHF management due to high hospitalization risk.”

# Documentation Examples: Audit Risks vs. Best Practice

- Generic EMR intervention
  - “Assess cardiovascular status each visit.”
  - “Teach disease process.”
  - “Monitor for signs and symptoms of exacerbation.”
- Problems
  - Vague and non-specific
  - No patient-specific risks identified
  - Does not demonstrate why skilled nursing is needed
  - Could apply to almost any patient

# Documentation Examples: Audit Risks vs. Best Practice

- Improved patient-specific intervention
  - “Assess for worsening CHF symptoms including increased dyspnea, weight gain greater than 2 lbs in 24 hours, bilateral lower extremity edema, and decreased activity tolerance due to recent hospitalization for CHF exacerbation. Reinforce low sodium diet, daily weight monitoring, and when to notify physician. Patient requires repeated instruction due to memory deficits and high risk for rehospitalization.”

# Documentation Examples: Audit Risks vs. Best Practice

- Generic EMR intervention
  - “Teach diabetic management.”
  - “Monitor blood glucose.”
  - “Assess medication compliance.”
- Problems:
  - No individualized teaching needs
  - No clinical complexity identified
  - No measurable focus

# Documentation Examples: Audit Risks vs. Best Practice

- Improved Patient-Specific Intervention
  - “Assess blood glucose log and evaluate for signs/symptoms of hypo/hyperglycemia due to recent uncontrolled blood sugar readings ranging from 65-380.
  - Instruct patient and caregiver on insulin administration technique, rotating injection sites, diabetic foot care, and recognition of symptoms requiring physician notification. Patient unable to independently manage insulin due to poor vision and dexterity limitations.”

# Documentation Examples: Audit Risks vs. Best Practice

- Generic EMR Intervention
  - “Review medications each visit.”
  - “Teach medication compliance.”
- Problems:
  - No indication why teaching is needed
  - Does not identify high-risk medications
  - No patient-specific barriers

# Documentation Examples: Audit Risks vs. Best Practice

- Improved patient specific intervention
  - “Review high-risk medications including anticoagulant and insulin therapy for adverse reactions, compliance, and effectiveness due to recent medication changes following hospitalization.
  - Instruct patient/caregiver on bleeding precautions, signs of hypoglycemia, and medication schedule. Patient requires caregiver assistance for medication setup due to cognitive impairment.”

# Documentation Examples: Audit Risks vs. Best Practice

- Minimal / Incomplete Recertification Order:
  - “Recertify patient for home health services.”
- Problems:
  - No skilled need identified
  - No disciplines listed
  - No frequencies/durations
  - No diagnosis or reason for continued services
  - No clinical justification for recertification
  - Does not support ongoing medical necessity

# Documentation Examples: Audit Risks vs. Best Practice

- Improved/defensible recertification order example:
  - “Recertify patient for skilled nursing services 1W9 for ongoing cardiopulmonary assessment, CHF symptom management, medication management education, and monitoring for exacerbation due to recent hospitalization for CHF. Patient remains homebound secondary to generalized weakness, dyspnea with minimal exertion, and requires walker with assistance for ambulation. Continued skilled nursing required to monitor response to treatment, reinforce disease management, and reduce risk of rehospitalization.”

# AI-Assisted Documentation & Clinical Record Integrity

- CMS Guidance on AI and OASIS Documentation
  - CMS clarified that agency software may not independently “answer” or “generate” final OASIS codes for clinicians.[4]
- Key expectations
  - The assessing clinician remains responsible for:
    - Reviewing all OASIS responses
    - Exercising independent clinical judgment
    - Verifying documentation accuracy
    - Ensuring consistency with assessment findings and guidance

# AI-Assisted Documentation & Clinical Record Integrity

- Potential risks of over-reliance on AI
  - Contradictory documentation
  - Generic or cloned narratives
  - Unsupported medical necessity
  - Inconsistent assessment findings
  - Increased survey and audit scrutiny
- Best practice
    - AI tools may assist with documentation workflow but:
      - Clinicians must validate all generated content
      - Documentation must reflect the actual patient assessment
      - Agencies should establish policies for AI documentation review

# Building Defensible Documentation

- What makes documentation defensible?
  - Tells the clinical story without requiring the reviewer to guess.
  - Supports medical necessity and skilled need for that visit.
  - Reflects patient-specific assessment, intervention, and response.
  - Aligns with the POC, orders, OASIS/comprehensive assessment, and goals.
  - Is timely, complete, accurate, and signed with appropriate credentials.
- Each note should stand alone
  - A reviewer should understand what happened today and why it mattered.

# Internal Compliance Strategies for Documentation Integrity

- Standards and policies
  - Documentation standards
  - Timeliness expectations
  - Late-entry/correction process
  - Copy-paste guidance
  - AI/EMR review expectations

# Internal Compliance Strategies for Documentation Integrity

- QA monitoring
  - Routine chart audits
  - Focused high-risk audits
  - Real-time review where appropriate
  - Trends and action plans
  - Pre-billing checks

# Internal Compliance Strategies for Documentation Integrity

- Oversight
  - Leadership accountability
  - Clinician coaching
  - Corrective action tracking
  - QAPI reporting
  - Repeat issue escalation

# Internal Compliance Strategies for Documentation Integrity

- Audit tools must measure the right things
  - Common audit tool problems
    - Marking “N/A” when the answer should be Yes or No
    - Auditing for form presence but not content accuracy
    - Missing POC-to-note alignment checks
    - Not reviewing medical necessity or skilled rationale
    - Not identifying trends across clinicians or disciplines

# Internal Compliance Strategies for Documentation Integrity

- Audit tools must measure the right things
  - Stronger audit process
    - Define when N/A is appropriate
    - Train auditors on clinical requirements
    - Use real examples from agency chart audits
    - Trend recurring issues
    - Link findings to education, corrective action, and QAPI

# Internal Compliance Strategies for Documentation Integrity

- Ongoing staff education
  - Leadership
    - Survey and audit risk
    - How to read trends
    - Accountability processes
    - Use of iQIES and QAPI
    - Repeat deficiency follow-up

# Internal Compliance Strategies for Documentation Integrity

- Ongoing staff education
  - QA/auditors
    - What each audit item means
    - Yes/No/N/A rules
    - Medical necessity review
    - POC-to-note alignment
    - Actionable feedback writing
      - Providing feedback that able to lead to measurable improvement

# Internal Compliance Strategies for Documentation Integrity

- Ongoing staff education
  - Clinical staff
    - Skilled documentation
    - Patient response
    - Timeliness
    - Credentials/signatures
    - Medication profile accuracy
    - Avoiding cloned content

# Internal Compliance Strategies for Documentation Integrity

- Use iQIES & HHVBP data to guide QAPI
  - HHVBP performance patterns
  - Outcome measures
  - Process measures
  - Potentially avoidable events
  - Declining or outlier performance
  - Measures that may reflect assessment, care planning, or documentation gaps

# Internal Compliance Strategies for Documentation Integrity

- Practical implementation checklist
  - Review top 10 documentation vulnerabilities in your last chart audits.
  - Re-check whether audit tools evaluate medical necessity, POC alignment, and patient response.
  - Train auditors on when “N/A” is appropriate.
  - Audit cloned/canned documentation across clinicians and disciplines.
  - Use iQIES/HHVBP data to select QAPI priorities.
  - Provide targeted staff education with weak vs. strong documentation examples.

# Key Takeaways

- Defensible
  - Every record should support medical necessity, skilled need, homebound status, and the plan of care.
- Consistent
  - The POC, OASIS/comprehensive assessment, visit notes, orders, and medication profile should tell the same story.
- Sustainable
  - Policies, QA, staff education, iQIES review, and leadership oversight make integrity part of operations

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# Thank you

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