Home Care Association of Florida | HomeCareCon

Under the Microscope

Illuminating Documentation for Medical Review

Strengthening defensibility against Palmetto GBA review, SMRC audits, and Pre-Claim Review under RCD

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SESSION OBJECTIVES

What You Will Take Away

Decode the Audit Landscape

Understand how Palmetto GBA TPE, SMRC project reviews, and Pre-Claim Review under RCD differ — and what each contractor is looking for in your record.

Identify Documentation Disconnects

Recognize where OASIS, the 485, visit notes, and the F2F encounter most often diverge — and how reviewers spot it instantly.

Translate Vague Language Into Defensible Language

Apply concrete charting techniques that move your record from 'patient tolerated visit well' to clinically specific, audit-ready prose.

Build a Pre-Bill QA Program That Holds

Implement real-time review checkpoints, clinician feedback loops, and AI-assisted audit tools that reduce ADR exposure before claims drop.

ROADMAP

Our 60 Minutes Together

1	**Setting the Stage** *Why documentation is under the microscope*	5 min
2	**Anatomy of a Denial** *What reviewers are actually looking for*	8 min
3	**The Documentation Disconnect** *Where agencies most often go wrong*	10 min
4	**OASIS Alignment & Clinical Accuracy** *High-risk items, PDGM, and case examples*	10 min
5	**Plan of Care Integrity** *Telling a consistent patient story*	7 min
6	**Building a Defensible Record** *Strategies, tools, and education that work*	7 min

01

SECTION

Setting the Stage

Why documentation has never been under more scrutiny

5 min

UNDER THE MICROSCOPE

1.1 THE LANDSCAPE

A Convergence of Review Activity

Home health is being reviewed from multiple directions at once — federal, contractor, and state. Each program has different triggers, different timelines, and different appeal rights, but they share a common requirement: a record that tells the patient's story without contradiction.

RCD / Pre-Claim Review

Operating in IL, OH, TX, NC, FL, and OK. CMS has signaled possible expansion to additional Palmetto GBA jurisdictions and has not closed the door on a national footprint.

ADR Volume

Additional Documentation Requests from Palmetto GBA TPE rounds remain elevated. ADR response windows are 45 days — a missed deadline is an automatic denial.

UPIC Investigations

Unified Program Integrity Contractors (CoventBridge, Qlarant, SafeGuard) pursue suspected fraud and abuse with broad authority — including unannounced site visits and payment suspensions.

TPE Cycles

Targeted Probe & Educate continues with 20–40 claim sample sizes per round. Three failed rounds escalates to 100% prepayment review or RAC/UPIC referral.

1.2 WHAT IS AT STAKE

The Financial & Operational Cost of Denials

$0

Reimbursement on a denied 30-day period of care — the full episode is unpaid

45

Days to respond to an ADR before automatic denial — clock starts at receipt

3

Failed TPE rounds before escalation to 100% prepayment or referral

BEYOND THE DOLLARS

- **Cash-flow disruption —** 60–90 days from ADR to appeal payment — a meaningful hit at any agency size
- **Workforce drag —** Clinical leadership pulled into ADR responses instead of patient-facing work
- **Reputational risk —** CERT error rates and TPE failure histories follow you into payer contracting
- **Survey vulnerability —** The same documentation gaps reviewers find are the gaps surveyors find

1.3 THE PARADIGM SHIFT

From Volume to Validation

THE OLD WORLD

Volume-Driven

- Episodes paid largely on submission
- OASIS treated as a billing input, not a clinical document
- Visit notes written for the chart, not for the reviewer
- Compliance handled reactively at appeal
- Documentation seen as a clinician burden, not a revenue function

THE NEW WORLD

Validation-Driven

- Episodes paid only when the record proves medical necessity
- OASIS, 485, and visit notes treated as a single integrated record
- Documentation written with reviewer logic in mind from day one
- Compliance built in pre-bill, not bolted on at appeal
- Documentation owned jointly by clinical, QA, and revenue cycle

SECTION

02

Anatomy of a Denial

What reviewers at Palmetto GBA, SMRC, and PCR are actually looking for

8 min

UNDER THE MICROSCOPE

2.1 COVERAGE FRAMEWORK

The Four Pillars Every Reviewer Tests

Whether the contractor is Palmetto GBA on a TPE round, Noridian on an SMRC project, or Palmetto's pre-claim review unit, the coverage analysis follows the same statutory framework. All four conditions must be supported in the record — failure on any one of them denies the entire 30-day period.

01

Physician Certification

Signed and dated certification of homebound status, need for skilled care, F2F encounter, and an established plan of care.

02

Homebound Status

Both criteria met and documented: a normal inability to leave home, AND that leaving requires a considerable and taxing effort.

03

Skilled Need

Care that requires the knowledge, skills, and judgment of a licensed professional — and care that is reasonable and necessary.

04

Plan of Care

Established and reviewed by the certifying physician, and the actual care delivered must conform to it.

2.2 HOMEBOUND STATUS

The Two-Criterion Standard Reviewers Apply

THE STANDARD

CRITERION ONE

The patient must either need supportive devices, special transportation, or another person's assistance to leave the home — OR have a condition where leaving is medically contraindicated.

CRITERION TWO

There must exist a normal inability to leave home, AND leaving home must require a considerable and taxing effort.

Both must be met and documented every cert period.

WHAT REVIEWERS REJECT

- ***"Patient is homebound."***
  Conclusory. No clinical basis given.
- ***"Uses walker."***
  States a device, not a taxing effort or normal inability to leave.
- ***"Generalized weakness."***
  Symptom without functional translation — no link to leaving home.
- ***"Patient drove self to physician visit on 3/14."***
  Documentation contradicts homebound status — automatic denial trigger.

2.3 SKILLED NEED

Establishing Clinical Necessity in the Record

A skilled service is one whose complexity is such that it can only be safely and effectively performed by — or under the supervision of — a licensed nurse or therapist. The reviewer's job is to find clinical specificity that supports that bar. The clinician's job is to put it there.

Observation & Assessment

- Tie the visit to a recent change in condition or unstable status
- Document specific signs you assessed and what they ruled in or out
- Note when stability is reached — that ends skilled coverage

Teaching & Training

- Identify the learner (patient, caregiver, both) by name and role
- Document teaching method, materials, return demonstration, and retention
- Show progression — same teaching every visit signals lack of progress or wrong learner

Management & Evaluation

- Document the complexity of the underlying condition that requires nursing oversight
- Show the unskilled services being managed and why they require skilled supervision
- Tie to a written plan of care that requires skilled coordination

2.4 THE ALF SETTING

Medical Necessity in the Assisted Living Facility

THE STANDARD

THE ALF IS THE HOME

An assisted living facility qualifies as the patient's residence for home health purposes, provided the facility is not primarily engaged in skilled nursing or medical care. Residing in an ALF does not, by itself, disqualify coverage.

HOMEBOUND STILL APPLIES

The same two-criterion standard applies — measured at the facility, not the room. Attending on-site meals and activities does not defeat homebound status; leaving the ALF must require a considerable and taxing effort.

Document the ALF context and homebound rationale every cert period.

WHAT REVIEWERS REJECT

- ***"Patient resides in ALF."***
  Setting is not a rationale — the homebound narrative is still required.
- ***"Attends facility activities daily."***
  Without the assistance and effort required, this reads as evidence against homebound.
- ***"Resident joined facility van outing."***
  Reviewers request ALF activity logs — independent community trips contradict homebound.
- ***"Admission source: institutional (ALF)."***
  ALF is a community source under PDGM — misclassification creates retroactive recoupment.

2.5 ALF SKILLED NEED

Skilled Need Without Duplicating Facility Services

Home health cannot pay for services the ALF is already obligated to provide under its state license or resident agreement. The reviewer's question in this setting: what is home health adding that facility staff cannot? The record must answer it explicitly.

Prove Non-Duplication

- Obtain the ALF service plan at SOC and reference it in the record
- Document what the facility provides — ADL support, med reminders or administration per state rules
- Show the skilled need sits beyond the facility's contractual obligations

Name the Right Learner

- ALF staff can be the taught caregiver — identify them by name and role
- Document return demonstration and how changes were relayed to the facility
- Staff turnover justifies re-teaching — but document the new learner each time

Coordinate the Record

- Align the 485 with the ALF service plan — conflicting stories invite denial
- Document communication with facility staff on condition changes and medication updates
- Aide services must not overlap ADL assistance the ALF already contracts to provide

2.6 F2F & CERTIFICATION

Where Technical Denials Live

Face-to-face encounter and certification deficiencies remain among the highest-volume denial reasons in Palmetto GBA's published TPE results — and the easiest for a reviewer to identify in a thirty-second skim of the record.

FACE-TO-FACE ENCOUNTER

- Performed by allowed provider 90 days prior to or 30 days after SOC
- Encounter date documented and tied to the primary reason for home health
- Clinical findings from the encounter reflected in the certifying record
- Cannot be a telehealth visit unless allowable under current CMS rules
- Encounter must support — not just exist alongside — homebound status and skilled need

CERTIFICATION

- Certifying physician's signature is legible, dated, and not pre-dated
- Certification statement includes all four required elements
- Recertification supported by clinical data showing continued need
- Verbal SOC orders signed within the agency policy timeframe
- Order content matches the OASIS, the 485, and the visit record

2.7 WHAT GETS DENIED

Top Rationales Across Palmetto, SMRC & PCR

Patterns recur across review programs. Audit your last six months of denials against this list — if any line shows up more than twice, build a pre-bill checkpoint specifically for it.

Denial Code / Rationale	What It Means	Most Common Source
5FF2F / 5F023	F2F encounter does not support homebound status or skilled need	Palmetto TPE & PCR
5HBND	Documentation does not establish patient is confined to the home	Palmetto TPE & PCR
5SKLE	Skilled service documentation does not support medical necessity	SMRC, Palmetto TPE
5DOCM	Information submitted did not include enough documentation	All programs
5CERT	Certification or recertification missing required elements	Palmetto TPE
5PLAN	Plan of care not signed timely or services not in accordance with plan	SMRC

03

SECTION

The Documentation Disconnect

Where the OASIS, the 485, the F2F, and the visit notes stop telling the same story

10 min

UNDER THE MICROSCOPE

3.1 THE FIRST DISCONNECT

OASIS Coding vs. The Clinical Narrative

Reviewers cross-reference OASIS responses against the SOC visit note, the 485, and subsequent visit notes. When the assessment says one thing and the narrative says another, the reviewer trusts neither — and the period of care is at risk.

OASIS Coding Says...	...But the Visit Note Says	Reviewer Reads This As
M1830 = 4 (total assist with bathing)	"Patient bathed self at sink, supervised"	Inflated functional score → questions PDGM grouping accuracy
M1400 = 0 (no dyspnea)	"SOB on ambulation to bathroom"	Either OASIS understates severity or note overstates — both deniable
GG0170C = 04 (set-up assist)	"Required two-person assist for chair to bed transfer"	Score does not match observed function — homebound rationale weakens
M2020 = 0 (independent w/oral meds)	"Daughter sets up weekly pill planner"	Patient is not actually independent — reviewer questions accuracy
M1810 = 0 (independent dressing upper)	"Required help donning shirt due to L shoulder pain"	Functional decline not captured — undermines skilled therapy need

3.2 THE SECOND DISCONNECT

Plan of Care Not Supported by Visit Notes

The 485 is a binding order. Every discipline, every frequency, and every goal on it must be actively reflected in visit documentation. When the plan promises something the chart does not deliver — or when the chart delivers something the plan does not authorize — both ends of the disconnect are reviewable.

Frequency Mismatch

485 says SN 2w9, but visit notes show 1w4 with no documented missed visit, hold, or order change

Discipline Gaps

PT discharge summary on the 485 but PT visits continued for two weeks — no order extension on file

Goals That Never Move

Identical goals carried forward from cert to recert with no progress narrative or measurable change

Interventions Without Orders

Visit notes show wound vac changes, IV care, or skilled teaching that does not appear on the 485

Orders Without Interventions

485 includes Foley change every 30 days but no visit note documents the change occurred

Stale Plan of Care

Significant change in condition (ER visit, new diagnosis, hospitalization) with no plan update

3.3 THE THIRD DISCONNECT

Copy/Paste & Template Hazards

EMR efficiency tools are not the enemy — but reviewers are trained to spot their fingerprints. Identical narrative across visits is the single fastest signal that the chart is not patient-specific.

REVIEWER RED FLAGS

- Identical pain ratings, vital signs, or wound measurements across multiple visits
- Same teaching topic with same response listed visit after visit
- Carried-forward homebound rationale with no patient-specific detail
- Visit narratives that read as nearly word-for-word identical
- Date or name of a prior patient appearing inside a current note (the smoking gun)

DEFENSIBLE TEMPLATE USE

- Use templates for structure — never for clinical observations or response to teaching
- Require a free-text patient-specific change-from-prior-visit field on every note
- Disable carry-forward on vitals, pain, wound size, and OASIS-driving items
- Build EMR alerts when narrative similarity exceeds a defined threshold
- Spot-audit 5% of notes monthly for template fingerprint patterns

3.4 THE FOURTH DISCONNECT

Vague vs. Defensible Clinical Language

Clinical specificity is the single most controllable variable in audit defense. The same clinician can write either the left column or the right column in the same amount of time — the difference is training, not effort.

VAGUE — Reviewer Denies	DEFENSIBLE — Reviewer Accepts
"Patient tolerated visit well"	*"Patient ambulated 30 ft x2 with FWW, requiring 30-sec rest after each pass; SpO2 dropped 96→91% on exertion"*
"Wound improving"	*"Sacral wound 2.1 x 1.8 x 0.3 cm, decreased from 2.8 x 2.4 x 0.5 last visit; granulation 80%, no slough, periwound intact"*
"Educated patient on medications"	*"Reviewed Eliquis 5 mg BID purpose, bleeding precautions, and missed-dose protocol with patient and son; both verbalized correct response to scenario question"*
"Patient is homebound"	*"Patient requires FWW and standby assist of one for ambulation; becomes SOB after 20 ft and fatigues to point of needing 10-min rest before attempting transportation"*
"Continue plan of care"	*"Continue SN 2w2 to monitor BP response to new lisinopril; 3 readings >160/90 this week — will reassess for MD notification next visit"*

SECTION

04

OASIS Alignment & Clinical Accuracy

High-risk items, PDGM impact, and case-based comparisons

10 min

UNDER THE MICROSCOPE

4.1 HIGH-RISK OASIS ITEMS

Where Reviewers Concentrate Their Attention

Not all OASIS items carry equal medical-review weight. The items below appear most often in Palmetto and SMRC findings — both because they drive PDGM payment and because they are the items most likely to contradict the visit narrative.

ADL & Functional Items

M1800–M1860 / GG0130 & GG0170

Drives functional impairment level under PDGM; reviewers cross-check against PT/OT eval and visit notes

Dyspnea

M1400

Ties to skilled need for cardiac and pulmonary diagnoses; high cross-reference rate against narrative

Medication Management

M2001–M2030

Reviewer favorite — must align with med list, teaching documentation, and skilled need rationale

Pain & Pressure Ulcers

M1242 / M1306 / M1311

Pressure ulcer items drive comorbidity adjustment; pain frequency must match assessment narrative

Home Environment & Fall Risk

M1100 / M1910

Supports homebound rationale; fall risk informs PT/OT skilled need and goal-setting

Diagnoses & Coding

M1021–M1023

Sets the PDGM clinical grouping; must match the F2F encounter, the 485, and the visit narrative

4.2 THE GOLDEN THREAD

Linking Functional Impairment to Skilled Need

Reviewers ask one question repeatedly: 'Why does this patient need a skilled clinician?' OASIS functional scores answer half of it. The visit narrative answers the other half. They must connect.

1 — ASSESS

Capture functional status accurately on OASIS; do not understate to ease the visit, do not overstate to influence PDGM

→

2 — TRANSLATE

Document in the visit narrative what the score means in this patient's daily life

→

3 — JUSTIFY

Explain why the impairment requires a skilled clinician — observation, teaching, or management

→

4 — PROGRESS

Show measurable change visit-over-visit — or document why progress has stalled and what changes

The Golden Thread: OASIS score → narrative description → clinical impact → skilled justification → measurable progress. If the chain breaks at any step, the reviewer denies.

4.3 CODING & PDGM

Documentation That Supports PDGM Grouping

PDGM payment is built from five independent variables, four of which trace directly back to documentation. The reviewer's question on each one is the same: does the record support what you billed?

Clinical Grouping	The principal diagnosis on the claim must be supported by the F2F encounter and reflect the primary reason for home health — not a comorbidity selected for grouping advantage
Functional Impairment Level	Driven by GG, M1800, M1810, M1820, M1830, M1840, M1850, M1860, and M1033 — every score must match the narrative and the therapy evaluation
Comorbidity Adjustment	Secondary diagnoses must be both documented in the medical record AND actively addressed in the plan of care during the period
Admission Source	Institutional vs. community must reflect where the patient was in the 14 days prior to SOC; misclassification creates retroactive recoupment
Timing	Early vs. late period determined by Medicare claims data, not agency entry — but documentation gaps on prior episodes can trigger downstream review

4.4 CASE STUDY — DENIED

How Poor Documentation Reads to a Reviewer

PATIENT | 78F, CHF exacerbation post-hospitalization, SN 2w2 + PT 2w2

OASIS CODES

M1400 = 2 (dyspnea w/ moderate exertion)
M1830 = 2 (assistance to wash entire body)
M2020 = 1 (independent if prepared)

VISIT NOTE (DAY 5)

"Pt seen for SN visit. Tolerated visit well. Lungs clear. No SOB. Educated on meds. VS stable. Continue POC."

WHAT THE REVIEWER SEES

- M1400 says "dyspnea on moderate exertion" but day-5 note says "no SOB" — which is true?
- No skilled service is described. Nothing nursing-specific occurred at this visit.
- Medication education is a single line — what was taught, who learned, what was the response?
- Bills CHF as primary, but the chart contains nothing CHF-specific (weight, edema, lung exam, output).

4.5 CASE STUDY — DEFENSIBLE

Same Patient, Same Visit, Different Record

PATIENT | Same 78F, CHF exacerbation post-hospitalization, SN 2w2 + PT 2w2

VISIT NOTE (DAY 5) — DEFENSIBLE NARRATIVE

"SN visit for CHF management following 4/2 hospitalization. Daily wt today 168 lb, down 1 lb from 4/14 visit (admit wt 173). Bilateral lower extremity edema 1+ pitting, decreased from 2+ on admit. Lung sounds: bibasilar fine crackles, unchanged. SpO2 95% RA at rest, dropped to 90% with ambulation 20 ft to bathroom — pt stopped, sat, recovered to 94% within 90 sec. Reports SOB only with exertion (matches M1400=2).

Reviewed daily weight log with pt and daughter — both able to identify the 3-lb-in-2-days notification threshold and demonstrated logging technique. Reviewed Lasix 40 mg AM; pt verbalized purpose and the importance of taking before noon. New script for spironolactone 25 mg daily — initial teaching today on purpose, K+ monitoring rationale, and to call agency for muscle weakness or palpitations.

Plan: SN to continue 2w2 to monitor diuretic response, daily weights, and reinforce dietary sodium limits — pt still struggling with restaurant intake per daughter. Will reassess discharge readiness when 7 consecutive stable weights documented."

Reviewer takeaway: Skilled need is unmistakable — assessment, teaching, evaluation, and ongoing management are all visible in one note.

SECTION

05

Plan of Care Integrity

Telling one consistent patient story from referral to claim

7 min

UNDER THE MICROSCOPE

5.1 THE CONTINUUM

One Story, Six Touchpoints

Reviewers triangulate. They pull the F2F, the OASIS, the 485, the visit notes, and the claim, and they read for contradiction. The defensible record reads identically across all six.

1	2	3	4	5	6
Referral & F2F	Start of Care	OASIS	Plan of Care (485)	Visit Notes	Claim

EVERY ONE OF THESE MUST MATCH ACROSS ALL SIX TOUCHPOINTS

Primary Diagnosis

ICD-10 code on claim must match F2F, OASIS M1021, and 485 (but not necessarily the claim)

Homebound Rationale

Same clinical reason in SOC note, OASIS, 485, and every visit

Skilled Need Rationale

Reason for home health is the same story regardless of which document is opened

Visit Frequency

What is ordered = what is delivered = what is billed; gaps require documented orders

5.2 THIRTY-SECOND RED FLAGS

What Reviewers See in Their First Skim

Experienced reviewers can flag a vulnerable record in under a minute. These are the patterns they look for first — train QA staff to find them before the chart leaves the building.

Backdated signatures
Cert signed after services began, or signature dates that defy reasonable workflow

OASIS scores that improve too fast
M1860 improves from 4 to 0 in two visits with no documented intervention to explain it

Identical visit narratives
Visit notes that read the same week after week — instant template signal

Goals never updated
Same goals on cert and recert with identical wording — suggests no clinical reassessment

F2F that does not address home health need
Encounter note about an unrelated condition, no mention of homebound or skilled need

Discharge summaries that contradict the period
DC summary says patient met all goals but recert was just submitted for ongoing skilled need

Missing or unsigned verbal orders
Phone orders captured but never returned signed — particularly for med changes

Therapy evaluations not used in OASIS
PT eval shows max assist required; OASIS scored as min assist — pick one

5.3 INTERDISCIPLINARY ALIGNMENT

When Disciplines Tell Different Stories

Reviewers read every discipline's note in sequence. When SN says the patient is independent with transfers and PT documents max-assist transfers two days later, the contradiction triggers scrutiny across the entire record — not just the disputed item.

Skilled Nursing

- Functional observations match what therapy documents
- Med list reconciliation matches MSW documentation of caregiver ability to manage
- Communication with therapy on shared goals visible in the note

Therapy (PT/OT/SLP)

- Eval functional scores align with OASIS GG and M1800–1860 items
- Discharge readiness statements consistent with SN visit observations
- Frequency reductions tied to documented progress, not arbitrary timing

Medical Social Work

- Caregiver capability assessment matches SN observations of who manages meds
- Home environment findings align with PT/OT safety assessment
- Resource interventions documented with measurable outcome

Home Health Aide

- Aide care plan reflects current ADL assistance level — not stale from SOC
- Documentation matches OASIS bathing, grooming, dressing scores
- Supervisory visit notes evaluate aide adherence to current plan

SECTION

06

Building a Defensible Record

Real-time technique, pre-bill QA, education that sticks, and AI assistance

7 min

UNDER THE MICROSCOPE

6.1 REAL-TIME TECHNIQUE

Documentation Improvement at the Point of Care

The most defensible documentation happens at the bedside, not at the kitchen table four hours later. Equip clinicians with a small number of high-leverage habits and audit results improve.

Document Before You Leave

Charts completed in the home contain 3x more clinical specificity than charts completed later that day

The 'Why Are You Here' Habit

Open every note by stating the patient-specific reason for the visit — never with assessment data

Show Your Assessment

Replace conclusions with observations — 'lung sounds with bibasilar crackles' rather than 'lungs abnormal'

Quantify Everything

Distance ambulated, time required, assistance level, vitals before and after — numbers beat adjectives

Close the Loop

End every note with what changes for next visit and what triggers MD notification

Name Every Person

'Daughter Susan demonstrated' not 'caregiver was instructed' — specificity defeats the boilerplate accusation

6.2 PRE-BILL QA

Catch It Before the Claim Drops

A pre-bill audit program prevents most ADRs from ever happening. The cost of a 15-minute QA review is a small fraction of the cost of an appeal — and prevents the workflow disruption of an ADR response.

DAY 1–5	**SOC Audit**	OASIS scrubbing, F2F validation, homebound rationale check, primary dx confirmation
DAY 14	**Mid-Period Check**	Visit note compliance with frequency, narrative quality spot-check, plan progression
DAY 25–30	**Pre-RAP/Pre-Final**	Full chart review for billable period — no claim drops without documented PASS
ONGOING	**Targeted Spot-Audit**	Random 5–10% sample monthly focused on prior-denial patterns and TPE topics

6.3 EDUCATION THAT STICKS

What Actually Changes Clinician Behavior

Annual all-hands compliance training does not move the needle. Behavior changes when feedback is timely, specific, and tied to the clinician's own charts.

DOESN'T MOVE THE NEEDLE

- Annual or quarterly group training sessions on OASIS or documentation generally
- Email blasts highlighting CMS rule changes without clinician-specific application
- PowerPoint reviews of denial letters with no individual clinician feedback loop
- Generic checklists handed out with no follow-up or accountability
- Punishing clinicians for QA findings without coaching them on the fix

ACTUALLY WORKS

- 1:1 chart-by-chart feedback within 48 hours of QA finding
- Showing clinician their own before/after narrative side-by-side
- Clinician scorecards with peer benchmarks (anonymized)
- Micro-learning — 10-minute weekly modules on a single specific item
- Pairing high-performing clinicians with those needing development

6.4 TECHNOLOGY ASSIST

Leveraging AI & Audit Tools for Consistency

Technology cannot replace clinical judgment, but it can catch the patterns no human reviewer can see at scale — and apply consistent standards across every clinician, every visit, every period.

Narrative Similarity Detection

Flags visit notes that exceed a defined similarity threshold to prior notes — catches copy/paste before audit does

OASIS-to-Narrative Cross-Check

Automated comparison of OASIS responses against visit-note free text for contradiction patterns

Pre-Bill Compliance Engine

Rule-based check of every claim for missing F2F elements, signature dates, and order alignment

Real-Time Narrative Coaching

Ambient or in-EMR prompts that suggest clinical specificity in the moment of charting

Predictive Risk Scoring

Identifies which patients are at highest risk for ADR or denial — concentrate QA where it matters

Clinician Scorecards

Tracks accuracy and consistency over time at the individual clinician level for targeted coaching

CLOSING

Five Things to Take Back to the Agency

01 The same chart is read by Palmetto, SMRC, and PCR — write for all three at once.

02 Documentation specificity is the single most controllable variable in audit defense.

03 OASIS, F2F, 485, visit notes, and the claim must read as one consistent story.

04 Pre-bill QA prevents ADRs; post-bill response only mitigates the damage.

05 Behavior change comes from chart-by-chart 1:1 coaching — not annual training.

Stay bright under the microscope.

Questions & Discussion

What is the single biggest documentation challenge at your agency right now?

RESOURCES TO BOOKMARK

Palmetto GBA palmettogba.com — TPE results, ADR letters, and education materials
Noridian SMRC noridiansmrc.com — current and recent project notifications and findings
CMS RCD cms.gov — operational guide and state-by-state implementation status