FREE OPERATIONAL RESOURCE

Home Health Pre-Bill Chart Readiness Checklist

A practical first-pass worklist for Medicare home health documentation and Medicaid EVV when applicable. Use current payer, state, and federal rules for every billing decision.

Agency		Review date	
Internal chart reference		Billing period	
Reviewer		Payer / plan	

1. Eligibility and certification

[ ]	Certification is complete before billing; the record supports homebound status and the need for qualifying skilled services.
[ ]	The face-to-face encounter date is documented, and the related clinical note or discharge summary is present in the supporting record.
[ ]	The certifying practitioner records and the agency chart tell a consistent clinical story for the period under review.

2. Plan of care and orders

[ ]	The plan of care covers the ordered disciplines, services, frequency, duration, diagnoses, goals, and precautions that apply to this patient.
[ ]	Required practitioner signatures and dates are present before billing; verbal orders are recorded, dated on receipt, and countersigned as required.
[ ]	Every material change in frequency, treatment, or discipline has a corresponding order and a clear chronology.

3. Visit and discipline documentation

[ ]	Each completed visit has a complete, signed, and dated note from the correct discipline.
[ ]	The documented service, assessment, intervention, and teaching are consistent with the active plan and orders.
[ ]	Missed, shortened, rescheduled, or changed visits have an explanation and any required practitioner notification or follow-up.

Privacy note Keep this blank public copy free of patient identifiers. If used internally with PHI, store it only inside the agency's approved HIPAA workflow.

Finish the cross-check before releasing the packet

4. EVV, authorization, and internal consistency

[ ]	For Medicaid services subject to EVV, the record includes service type, recipient, service date, location, provider, and start/end times.
[ ]	Visit note, EVV record, schedule, and billed discipline agree; differences are explained and resolved before billing.
[ ]	Payer authorization number, effective dates, approved discipline, frequency, and units cover the services being billed.

5. OASIS and reporting checks

[ ]	When OASIS applies, the completed assessment is transmitted within 30 days after completion under the current federal rule.
[ ]	The agency used the current OASIS data set and checked the current CMS quality-reporting submission and correction calendar.
[ ]	The assessing clinician - not software - reviewed the available evidence and selected every final OASIS response.

6. Final billing readiness

[ ]	The payer, billing period, orders, visits, authorization, EVV, and supporting records align for the packet being released.
[ ]	Every blocker has been resolved or has a named owner and due date; unresolved blockers are held from billing.
[ ]	A designated human reviewer recorded the final Ready, At risk, or Hold decision and retained the supporting worklist.

Blocker worklist

Blocker / mismatch	Owner	Due	Resolved
			[ ]
			[ ]
			[ ]

FINAL STATUS **[ ] READY** **[ ] AT RISK** **[ ] HOLD** Reviewer initials: _____

Primary sources (checked August 9, 2026)

- CMS Medicare Benefit Policy Manual, Chapter 7
- CMS: Home Health Care - Proper Certification Required
- 42 CFR 484.45: OASIS reporting
- Medicaid.gov: Electronic Visit Verification
- CMS: HH QRP data submission deadlines

This checklist is a general operational aid, not legal, clinical, coding, or billing advice and not a guarantee of payment. Payer contracts, state requirements, and the current official guidance control. ChartReady flags documentation for human review; it does not select final OASIS responses, sign records, or submit claims.