

Home Health Quickflips© #20

Progress Notes and Discharge Summary

Progress notes and the discharge summary can paint a picture of the patient and the outcomes of home health care. Some agencies use progress notes routinely, while others utilize visit notes as progress notes, accompanied by 60-day summaries. Adhere to your agency policy.

A progress note should answer three questions:

1. What was the patient's prior clinical and functional status?
 2. What is the patient's current clinical and functional status?
 3. What is the anticipated clinical and functional picture?
- Are there changes in the Plan of Care?
 - What is the rehab potential and progress toward goals?

Upon discharge:

- Ensure that all disciplines have discharged the patient from service in a timely fashion.
- When writing the discharge summary, include everything that is addressed in a progress note, plus the reason for discharge and any additional services the patient will have after discharge from home health.
- Notify the patient's physician of discharge per agency policy. For example, send discharge summary or physician order as notification.

Home Health Quickflips© #25

M0110: Episode Timing

This M item asks, “Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode of a "late" episode in the patient's current sequence of adjacent Medicare home health payment episodes?” It identifies the placement of the current Medicare PDGM payment period in the patient's current sequence of adjacent Medicare PDGM payment periods. For payment purposes, CMS will determine early or late based on Medicare claims data.

Remember, CMS defines “early” as the first 30 day period of home health care provided. “Late” is considered the second or greater adjacent 30-day payment period of care. Although CMS no longer uses M0110 for payment, other payors may use this data in their PPS-like payment models. Helpful hints to more clearly define:

- Adjacent payment episodes are defined as those where the number of days from the last day of one episode until the first day of the next episode is not greater than 60.
- A 60-day break is considered by the end of the prior 60-day episode date, or the “to-date” on the final claim. This date may be later than the last visit the patient received.
 - “UK” can be used if the timing is unknown, or if agency chooses to use as default.
 - “NA” can be used where the data is not required for the patient's payer (including all Medicare FFS assessments).