Olli Health

CHAP VERIFIED

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Audit-Ready by Design

What CMS actually looks for in OASIS and coding documentation, and why most agencies find out the hard way



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01

Why documentation gets questioned long after it was written

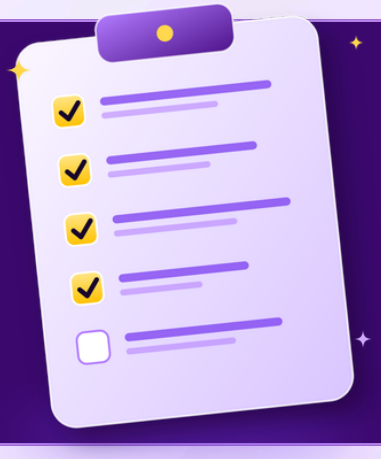
A request for records usually reaches an agency months after the care it covers. By then the clinician has moved on to dozens of other patients, and the chart has to speak for itself.

Reviewers read a chart differently than the clinician wrote it. They compare the OASIS, the visit notes, the plan of care, the orders, and the claim, and they look for places where those records tell different stories.

This paper walks through how reviews tend to start, what reviewers compare, and the documentation patterns that most often draw questions. It also includes a self-check your team can run on a small sample of charts this week, a short list of what to do now to protect your revenue, and the case for adding a second layer of review before claims go out.

It's written for directors of nursing and quality leaders who want a practical, steady look at where their charts stand. Nothing here requires a new system to get started.

> “
>
> **The chart has to speak for itself.**



02

How reviews and audits actually start

Several of the main review paths begin with claims data or random sampling, so a chart can be pulled without anyone at the agency doing anything unusual. These are the paths that show up most in current CMS and OIG material.



Error rate testing

Who runs it: CMS

Randomly sampled claims. CMS put the 2023 home health improper payment rate at 7.7 percent, about $1.2 billion (OIG).



OIG compliance audits

Who runs it: OIG

OIG uses computer matching, data mining, and data analysis to pick agencies at risk. It then reviews a sample of 100 claims with an independent medical review contractor (OIG).



Review Choice Demonstration

Who runs it: Medicare Administrative Contractor

Agencies in Illinois, Ohio, Texas, North Carolina, Florida, and Oklahoma (and soon California) choose pre-claim or postpayment review, and can earn relief by reaching a 90 percent affirmation rate (CMS).



Claim reopening

Who runs it: Medicare Administrative Contractor

A contractor can reopen a claim for good cause within 4 years of the initial determination (OIG).

The rules are moving in the same direction

In the CY 2027 home health final rule, issued November 4, 2026, CMS made all Medicare enrollment revocations effective as of the date noncompliance began, which lets the agency recover payments dating back to that point (CMS). CMS estimates the change will save about $82 million a year, and the rule adds new grounds for denying or revoking enrollment.

$82M
estimated yearly savings from retroactive revocations

135 → 45
days to submit OASIS data for quality reporting

98%
of agencies already submit within 45 days

The final rule also shortens the OASIS data submission deadline for quality reporting from 135 days to 45 days, starting with the CY 2027 reporting year. CMS says about 98 percent of agencies already submit within 45 days (CMS). The payment and quality reporting provisions take effect January 1, 2027, and the rule is scheduled for Federal Register publication on November 9, 2026 (Federal Register).

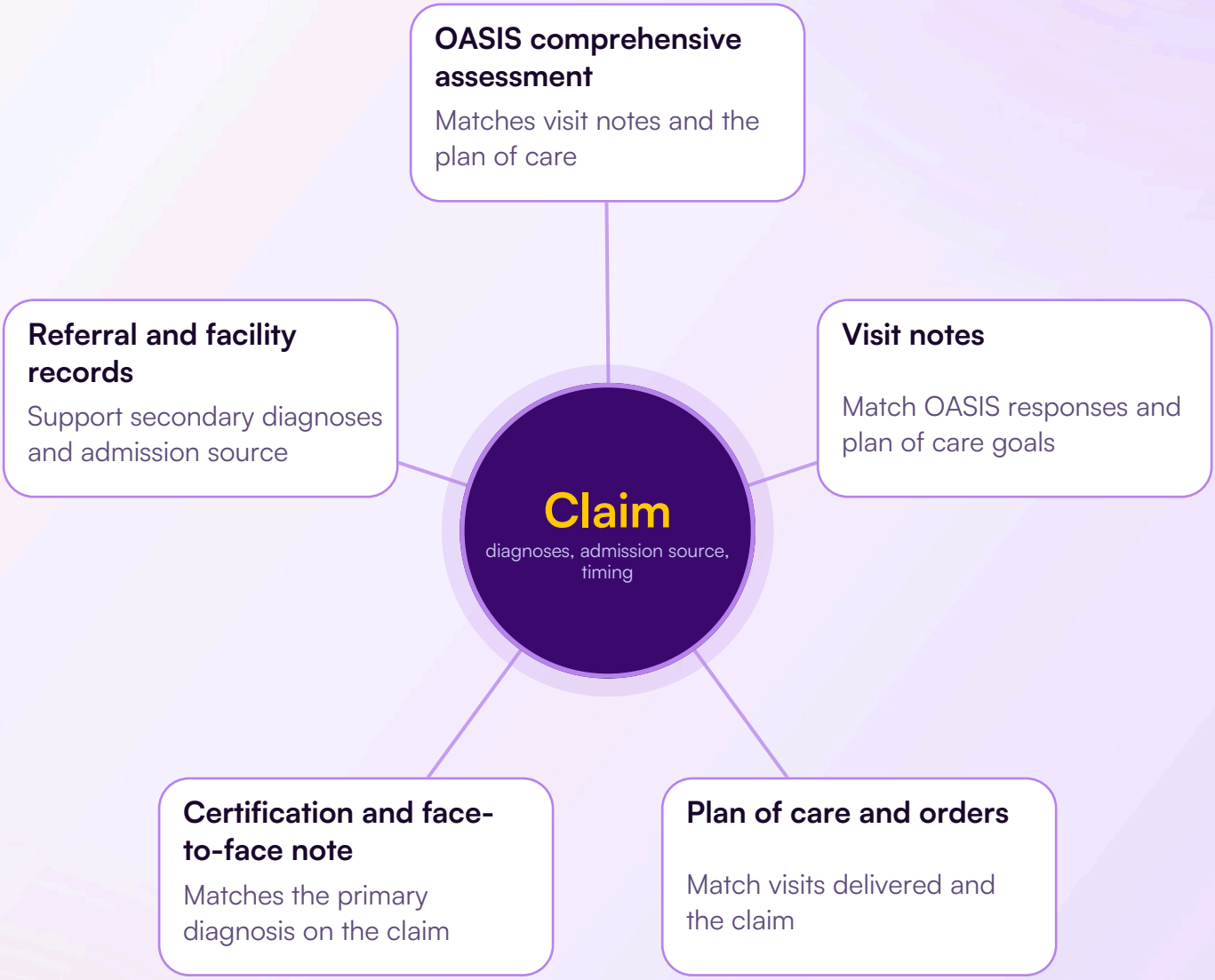
For documentation, the takeaway is simple. A reviewer works from the record as it stands, usually long after the visit, and each record has to say the same thing on its own.



03

What CMS compares

Reviewers check whether six records agree with each other, so a gap between any two of them can start a question. The claim sits at the center, because its diagnoses, admission source, and timing drive the payment group.



Record	What it should show	What a reviewer compares it to
OASIS comprehensive assessment	The patient's current health and functional status. CMS requires OASIS data as a condition of payment, sent within 30 days of completing the assessment.	Visit notes and the plan of care
Visit notes	The skilled need, plus what the clinician saw and did at each visit	OASIS responses and plan of care goals
Plan of care and orders	Treatments, disciplines, and visit frequency, reviewed and signed by the practitioner at least every 60 days	Visits actually delivered and the claim
Certification and face-to-face note	Homebound status, skilled need, and a face-to-face encounter related to the primary reason for care, within 90 days before or 30 days after start of care	The primary diagnosis on the claim
Referral and facility records	Where secondary diagnoses come from, and the setting the patient came from	Secondary diagnoses and admission source on the claim
Claim	Principal and secondary diagnoses, admission source, and period timing	Every record above

Source: requirements as summarized in OIG's home health compliance audits (Alternate Solutions, A-05-24-00007).

A useful habit is to read a chart the way a reviewer would. Start at the claim, then trace each diagnosis, score, and date back to a record that supports it.

6 records reviewers compare

5 documentation patterns that draw questions

8 checks you can run this week

04

Five documentation patterns that draw questions

These five patterns show up repeatedly in recent OIG audits, and each one connects to how the payment group is built.

1 Functional answers that don't match the visit notes

The PDGM functional impairment level comes from OASIS items M1800 through M1860 and M1033, which cover grooming, bathing, dressing, ambulating, transferring, and risk for hospitalization (Federal Register). Each answer is a judgment made on one day, and a reviewer reads it next to the visit notes.

GG items work differently. They feed the Discharge Function Score in the Home Health Quality Reporting Program rather than the payment group. In the final rule, CMS said it will continue to evaluate whether GG items could be used for payment (Federal Register).

Quick check: for five recent charts, find the visit note sentence that supports each bathing, dressing, and transferring answer.

2 Secondary diagnoses on the claim without support in the record

A secondary diagnosis on the claim has to be supported by the certifying practitioner's or facility's medical record (OIG). One secondary diagnosis from CMS's comorbidity list earns a low adjustment, and two or more that CMS lists as interacting earn a high one. For CY 2027, CMS finalized 22 low comorbidity subgroups and 103 high comorbidity interaction subgroups (Federal Register).

CMS monitoring data shows why this gets attention. In the proposed rule's analysis of preliminary 2025 claims, the share of 30-day periods with no comorbidity adjustment fell from 49.1 percent in 2020 to 24.1 percent in 2025 (HFMA summary).

In OIG's August 2026 audit of one agency, 26 claims carried unsupported secondary diagnoses that did not change the payment group. That's how they can sit unnoticed, and OIG still counted each one as a billing and coding error.

Quick check: pick one secondary diagnosis on each of five claims and find where it's documented in the referral, practitioner note, or facility record.

3 A face-to-face note that doesn't match the primary diagnosis

The face-to-face encounter has to relate to the primary reason for home health. It also has to happen no more than 90 days before or within 30 days after the start of care (OIG).

In that same August 2026 audit, five claims failed this test. Three had an encounter unrelated to the primary reason, and two had no encounter documented. In one example, the primary reason was gastritis, while the note addressed pain, mobility, and the need for physical therapy (OIG).

✓ **Quick check:** for each chart, put the primary diagnosis on the claim next to the reason stated in the face-to-face note.

4 Admission source and period timing

A patient discharged from an acute or post-acute facility within 14 days before the claim start date counts as an institutional admission. All other admissions are community admissions (OIG). Institutional admissions typically pay more, so the record needs to show the facility stay.

OIG found one agency coded an institutional admission for a patient who came from the community after an emergency room visit with no inpatient stay, which created a $940 overpayment. OIG's work plan also lists a nationwide audit of claims billed with institutional admission occurrence codes 61 or 62.

Errors can run the other way too. In another audit, an unsupported late-episode code and an unsupported primary diagnosis each led to an underpayment, totaling $1,716.

✓ **Quick check:** for every institutional claim, confirm the chart holds a record of an inpatient or facility stay, since emergency room and observation-only visits don't qualify.

5 Plan of care, visit counts, and OASIS timing

The practitioner has to review and sign the plan of care at least every 60 days, with signature and date. OASIS data has to reach CMS within 30 days of completing the assessment (OIG).

Visit counts matter too. A 30-day period is paid in full when it meets the visit threshold for its payment group, which is the 10th percentile of visits or 2 visits, whichever is higher. Periods below the threshold are paid per visit (Federal Register). For CY 2027, CMS finalized new thresholds, with 10 payment groups dropping by one visit and one group rising by one. The visits delivered have to match the plan of care and the claim.

In OIG's February 2026 audit, two claims missed the OASIS transmission deadline, and the agency pointed to temporary staffing shortages. Neither created an overpayment, because the visit threshold was met and the payment group didn't change.

Quick check: list every plan of care still waiting on a signature and every OASIS not yet transmitted.

05

Why most agencies find out the hard way

Feedback on a chart usually arrives years after it was written, so a habit can repeat across thousands of charts before anyone sees it.



Source: OIG audit A-05-24-00007.

A second OIG audit, issued in February 2026, covered claims from 2022 and 2023. Contractors can also reopen a claim within 4 years of the initial determination.

The same delay exists inside the agency. The clinician who wrote the record rarely sees it next to the claim, so a small habit can repeat for months. A functional answer carried forward from the last visit is one example, and a diagnosis copied over from a referral is another.

In the February 2026 audit, the agency said its internal pre-payment review didn't catch the coding errors, and that temporary staffing shortages affected OASIS timing (OIG). Those are ordinary workflow gaps, the kind that appear when review depends on whoever has time that week. OIG's recommendation points the same way, since it asked the agency to consider internal audits of later claims to find similar problems.

- Training matters, and it changes what a clinician does going forward. A second reader catches what slipped through before the claim is billed.

37 of 100

sampled claims had errors in the August 2026 OIG audit

30 of 37

of those claims did not change payment



06

A self-check you can run this week

Pull 10 to 15 recent charts from several clinicians and run the eight checks below. Ask someone other than the clinician who wrote each chart to do the review, since a second reader finds what the author reads past.

1	**Functional answers** OASIS and visit notes	PASSES WHEN Each bathing, dressing, grooming, ambulation, and transferring answer has a supporting sentence in a visit note	☐ P	☐ F
2	**Hospitalization risk answers** OASIS and visit notes	PASSES WHEN Each risk answer matches what the notes describe	☐ P	☐ F
3	**Secondary diagnoses** Claim, referral, practitioner and facility records	PASSES WHEN Each secondary diagnosis on the claim traces to a source record	☐ P	☐ F
4	**Primary diagnosis** Claim, plan of care, face-to-face note	PASSES WHEN The same primary reason appears in all three	☐ P	☐ F
5	**Face-to-face encounter** Certification	PASSES WHEN Dated within 90 days before or 30 days after start of care, and related to the primary reason	☐ P	☐ F
6	**Admission source** Claim and facility records	PASSES WHEN Institutional claims include a record of an inpatient or facility stay	☐ P	☐ F
7	**Plan of care** Orders and visit log	PASSES WHEN Signed and dated within 60 days, and visits delivered match the ordered frequency	☐ P	☐ F
8	**OASIS timing** Submission records	PASSES WHEN Transmitted within 30 days of completing the assessment	☐ P	☐ F

Count failures by check instead of by chart. One failure may be a one-off, while the same failure across several clinicians points to a process gap that coaching or a review step can close.

Keep the results and run the same check again next quarter. A repeat run shows whether a fix worked.

07

What to do now to protect your revenue

The fastest way to protect revenue is to make sure every code the record supports is on the claim, and every code on the claim is supported. Missed codes mean missed revenue, and unsupported codes mean audit risk, so the same habits protect both.

1. **Run the self-check this week.**
   Ten to fifteen charts will show which of the five patterns your team hits most often.

2. **Fix the check that fails most.**
   Start with diagnoses and functional answers, since they set the payment group.

3. **Look for what's missing as well as what's wrong.**
   A diagnosis the record supports but the claim leaves off can lower the comorbidity adjustment.

4. **Trace every secondary diagnosis to a source record before billing.**

   That also protects the claim if a records request arrives.

5. **Get ready for January 1.**
   CMS updates the functional points, comorbidity subgroups, and LUPA thresholds every year, and the 2027 versions take effect January 1. Confirm your team and your coding workflow are using them.

6. **Put a second reader in front of the claim.**
   The next section covers how.

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Why a second layer of review is a best practice

80% of home health agencies outsource coding and/or OASIS and plan of care quality review to specialized vendors (estimated)

A second layer of review is a best practice, and most agencies now bring in outside expertise for it. An estimated 70 to 80 percent of home health agencies outsource coding and/or OASIS and plan of care quality review to specialized vendors. This gives agencies access to expert oversight while providing the flexibility to scale capacity as they grow, manage staffing shortages, or navigate fluctuations in volume.

A second layer works because it adds a reader who sees the whole file before the claim is billed. Agencies take a few routes:

A managed service

A specialized vendor reviews the work, so you add expert oversight and flexible capacity without adding a role. This is the route most agencies take.

A dedicated internal reviewer

Before claims are submitted, a trained reviewer checks a sample of charts against the eight criteria above. To ensure a meaningful quality review, this person should be well-versed in current CMS guidelines and hold certifications in home health coding and OASIS.

Whichever route you choose, hold it to the same standard. Ask how many reviews its accuracy number is based on, who checks the work, and whether the results are published.

Olli Health

Olli helps agencies protect reimbursement and improve margins by pairing AI with certified coders and OASIS reviewers. The AI captures, drafts, and codes the visit, and certified experts validate documentation, ICD-10 codes, and OASIS accuracy and compliance.

An AI-only tool can only code from the documentation it's given, so a vague wound description or a missing diagnosis detail carries straight through to the claim. Olli's certified expert coders flag unclear or incomplete documentation and help the agency get it clarified before the claim goes out. That supports compliant coding that reflects the full clinical picture.

Olli publishes its accuracy report every quarter. In Q3 2026, its QA team completed 2,522 retrospective reviews of its own team's work, and overall accuracy held at 97.5 percent. If a vendor won't share theirs, it's fair to ask why.

Faster turnaround | **Better accuracy** | **About half the cost of legacy vendors**

Agencies that work with Olli get faster turnaround, better accuracy, and a cost about half that of legacy vendors.

If you'd like to experience Olli's speed, accuracy, and customer support firsthand, we offer a 30-day, low-risk pilot you can opt out of at any time.

Reach out to Jay Banks
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Sources and further reading

Sources were gathered in October and November 2026. CMS issued the CY 2027 final rule on November 4, 2026, and its payment and quality reporting provisions take effect January 1, 2027.

Source	Used for
CMS: Review Choice Demonstration for Home Health Services	Demonstration states, review choices, and the 90 percent affirmation rate
CMS press release: CY 2027 home health final rule (November 4, 2026)	Retroactive revocations, new enrollment grounds, and the 45-day OASIS deadline
CMS fact sheet: CY 2027 home health final rule, CMS-1844-F	Final payment, quality reporting, and enrollment provisions
Federal Register: CY 2027 HH PPS final rule, CMS-1844-F (public inspection copy)	Functional impairment items, comorbidity subgroups, LUPA thresholds, and effective dates
HFMA: CY 2027 HH PPS proposed rule summary	Comorbidity trend data from the proposed rule's analysis of preliminary 2025 claims
OIG: Alternate Solutions Homecare of Dayton, A-05-24-00014 (February 2026)	Error rate testing figures, documentation requirements, admission source, and OASIS timing findings
OIG: Deistic Home Health Care, A-05-24-00007 (August 2026), AAPC-hosted copy	Unsupported diagnosis findings, face-to-face findings, claim reopening, and audit timeline
OIG work plan: nationwide audit of institutional admission source claims	Current OIG focus on admission source