

MEDICARE CHARTING GUIDELINES

Resident Name: _____ Date of Admission: _____ / _____ / _____

Admitting Dx (Main): _____

Other Dx: _____

Guidelines:

1. Chart Q Day.
2. Use this guideline to focus your charting.
3. Guidelines to be completed by Medicare Nurse, Unit Manager, or other Nursing Supervisor.

REASON FOR SKILLING ON MEDICARE:

- o Physical Therapy o Occupational Therapy o Speech Therapy o Respiratory Therapy o Unstable IODM o Injections (IM only) o New G-Tube Feeding
- o Decubitus/Ulceration (I or Stage III) o Stage IV or Multi-Stage II o Other Wounds (i.e. w/ Surgical complications) o I.V. Therapy o Straight Catheterization
- o Colostomy/Ileostomy Care o Medication Adjustment o Dehydration/Malnutrition o Isolation o Patient Teaching/Nursing Routines
- o Medically Unstable Condition o Cardiovascular Compromise o Gastrointestinal Complications o Circulation Problems o Hemodialysis (w/ complications)
- o

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	
<ul style="list-style-type: none"> o Physical, Occupational Therapy <ul style="list-style-type: none"> - Describe exactly how the resident performs ADLs. - Describe the amount of assistance provided. - Describe how the resident accomplishes the following: <ul style="list-style-type: none"> ▪ Bed Mobility ** ▪ Transferring ** ▪ Ambulates ▪ Dresses Self ▪ Eats (including G-Tubes)** ▪ Toilet Use (including Post-Use Hygiene)** ▪ Personal Hygiene and Bathing - DESCRIBE SKILLED NURSING INTERVENTIONS USED TO COMPENSATE FOR ADL DEFICITS <p>** (Indicates one of the 4 LATE LOSS ADLs which assign an ADL Index Score for RUG calculation)</p> <ul style="list-style-type: none"> o I.M. or I.V. Medication Administration <ul style="list-style-type: none"> - Describe nature of medication used (include reason for use) and nursing skills and observations used in administration of medication. - Describe effectiveness of medication and any side effects observed. - Describe how resident tolerated such therapy (i.e. IV infiltration, fluid volume overload, pain, phlebitis, etc.) <ul style="list-style-type: none"> o Surgical Wounds or Open Lesions (does not include rashes, ulcers and cuts) <ul style="list-style-type: none"> - Describe location and nature of wound. - Describe any pain re/ to surgical wound and interventions used to combat pain. - Describe nursing interventions and observations re/ surgical wound healing process. - Describe any drainage, areas of increased erythema, or warmth. - Describe response to any treatments ordered. - At least q week, describe in detail wound healing process and response to tx. 	<ul style="list-style-type: none"> o Speech Therapy <ul style="list-style-type: none"> - Describe Exactly how the resident communicates and makes needs known. - Describe skilled nursing interventions used to compensate for speech deficits. - Describe residents ability to swallow foods and skilled nursing interventions used to compensate for impaired swallowing abilities. <ul style="list-style-type: none"> o Unstable IODM <ul style="list-style-type: none"> - Describe amount of order changes and physician visits (Requires in the past 14 days 2 order changes and 2 MD visits OR 4 order changes) - Describe any skilled nursing interventions used to teach resident self administration. - Describe outcome of resident teachings. - Describe any signs and symptoms associated with fluctuating blood sugar levels. 	<ul style="list-style-type: none"> o Respiratory Therapy / Impaired Respiratory Status <ul style="list-style-type: none"> - Describe skilled trach care rendered. - Describe accurately breath sounds over all lung aspects (i.e. wheezes, rales, ronchi). - Describe respiratory rate, rhythm and quality. - Describe the effectiveness of any respiratory treatments given (i.e. Nebulizers, Chest PT, Other Respiratory Medications, Oxygen, etc). - Describe residents comfort level as re/ respiratory status. - Describe any changes in LOC, anxiety or other mental status changes. - Describe each incident of suctioning and any other invasive techniques. - Describe residents overall condition as re/ respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status. <ul style="list-style-type: none"> o New Gastrostomy Tube Feeding <ul style="list-style-type: none"> - Describe amount of fluids/feedings delivered. - Describe resident's ability to communicate and make needs known to staff. - Describe how resident tolerated tube feeding <ul style="list-style-type: none"> - specifically any adverse effects to feeding such as diarrhea, abdominal distension, Cardiac symptoms, abnormal lung sounds. - Describe type of ostomy care rendered around G-Tube site and condition of site. - Describe clinical necessity for G-Tube/J-Tube <ul style="list-style-type: none"> o Straight Catheterization / GI Complications <ul style="list-style-type: none"> - Describe nature of resident's condition that warrants the use of straight catheterization techniques. - Describe use of sterile technique during catheter administration. - Describe any resident teaching re/ catheter use. - Describe any clinical conditions present that require skilled nursing observation (such as frequency, dysuria, indicators of UTI, etc) 	<ul style="list-style-type: none"> o Decubitus Ulceration (Stage III or IV or Multi- IIIa) <ul style="list-style-type: none"> - Describe condition of wound. - Describe response to current treatments. - Describe nursing interventions used to prevent further ulcer development. - Describe skilled nursing interventions used to aid in wound healing. - Describe consumption amounts of meals and fluids provided. - Describe overall skin condition including poor skin turgor, bruises, rashes, cyanosis, redness, edema or other abnormality. <ul style="list-style-type: none"> o Document any interventions implemented re/ abnormal lab values (i.e. low H&H, low serum albumin, low Fe+ levels, etc). o Describe dietary interventions implemented such as increased vitamin C and protein foods offered. o At least q week, describe in detail wound measurements, locations and response to treatments.

Medicare Charting Guidelines Snf

Donna Batten

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Straight to the Point Documentation Guide for LTC/SNF Nurses Klk Nursing Strategies,2020-11-23 Tired Of Being Hassled for Documentation as a Nurse in a LTC SNF A Straight To The Point Guide From MDS Coordinators What Exactly It Is We Need From Your Medicare Documentation An easy to use reference made for Nurses in the long term care setting We have gathered that in Nursing school we re taught to document or it didn t happen and on the job tells you to document but you re never given the specifics of what exactly is needed This is why this reference guide was created by MDS Coordinators for LTC SNF Nurses Who better to hear it from than MDS Nurses themselves Bridging the knowledge gap 1 Nurse at a time

Medicare and Medicaid Guide ,2006 *Documenting Care* Frances Talaska Fischbach,1991 University of Wisconsin Milwaukee School of Nursing s comprehensive charting and documentation manual for students and practitioners

Manual of Nursing Home Practice for Psychiatrists American Psychiatric Association,2008-11-01 The shifting demographic toward a graying population coupled with today s reality of managed care makes the need for high quality cost effective psychiatric services within the nursing care setting more urgent than ever As we increase the number of our years it is also imperative that we enhance the quality of those years The product of the American Psychiatric Association s APA s Council on Aging and its Committee on Long Term Care and of the Elderly the Manual of Nursing Home Practice for Psychiatrists stands out because it focuses on the how not the why of nursing home care Of exceptional importance is its detailed discussion of the Minimum Data Set MDS a structured assessment required by both Medicare and Medicaid for all residents of skilled nursing facilities Divided into six sections this how to volume contains practical information readers can use right away from getting reimbursed by insurance companies to handling nursing facility politics Clinical History evaluation and management of psychiatric problems in long term care patients an overview of the MDS sexuality within the nursing home care setting Regulatory Introduction to the Nursing Home Reform Act of 1987 part of OBRA 87 and its implications for psychiatric care details about the Resident Assessment Instrument RAI which includes the MDS the Resident Assessment Protocols RAPs and Utilization Guides specified in the State Operations Manual SOP Financial Documentation reimbursement and coding what to look for when contracting with nursing homes Legal and ethical The dehumanizing effect of diagnostic labels and the ethical issues inherent in regulating daily schedules e g bed meal and bath times nursing home placement competence and decision making ability comfort care for end stage dementia coping with Alzheimer s disease and the role of caregivers Summary and Future Perspectives A detailed vision about how psychiatrists can improve the diagnosis and treatment of nursing home patients Appendixes and bibliography Staffing recommendations and assessment instruments Edited by a distinguished authority and former chair of the APA s Committee on Long Term Care and Treatment of the Elderly this comprehensive volume will appeal to a wide audience of professionals from general psychiatrists nurse practitioners and clinical nurse specialists to primary care physicians and residents Fordney's Medical Insurance and

Billing - E-Book Linda M. Smith, 2024-08-07 Gain the skills you need to succeed in insurance coding and billing Fordney's Medical Insurance and Billing 17th Edition helps you master the insurance billing specialist's role and responsibilities in areas such as diagnostic coding, procedural coding, HCPCs coding, medical documentation, billing and collection. Using clear explanations, this book covers all types of insurance coverage commonly encountered in hospitals, physicians' offices, and clinics. Step-by-step guidelines lead you through the submission of electronic claims and paper claims, as well as the job search and professional advancement. Written by coding specialist and educator Linda M. Smith, this market-leading text is a complete guide to becoming an efficient insurance billing specialist. NEW: HCPCs Coding chapter covers ambulance billing, supply billing, and certificates of medical necessity. NEW: Content on professionalism includes customer service, conflict management, diversity awareness, leadership, and other competencies to help you become an effective, engaged, and highly functioning employee. NEW: Additional content on medical decision making helps you select the appropriate evaluation and management codes under the current documentation guidelines. NEW: Additional examples of CMS claims include those from Blue Shield and Automobile Insurance. NEW: Updates to credentialing include those specific to Medicare, Medicaid, and Workers' Compensation. Coverage of medical documentation, diagnostic coding, and procedural coding provides you with the foundation and skills needed to work in a physician's office, as well as ambulatory and inpatient settings. Coverage of the role and responsibilities of the insurance billing specialist emphasizes advanced job opportunities and certification. Chapter on HIPAA compliance, as well as Compliance Alerts, highlight important HIPAA compliance issues and the latest regulations. Step-by-step procedures detail common responsibilities of the insurance billing specialist and coder. Key terms and abbreviations are defined and emphasized, reinforcing your understanding of new concepts and terminology. Color-coded icons denote and clarify information rules and regulations for each type of payer. Insights From The Field includes more interviews with experienced insurance billing specialists, providing a snapshot of their career paths and offering advice to the new student. Scenario boxes help you apply concepts to real-world situations. Quick Review sections summarize chapter content and also include review questions. Student Software Challenge on the Evolve website allows you to practice filling out interactive CMS 1500 forms.

Preparing for the Occupational Therapy National Board Exam Joseph Michael Pellerito, 2010-10-22 A comprehensive overview for occupational therapy students preparing to take the National Board for Certification in Occupational Therapy (NBCOT) exam. Containing more than just study questions, this comprehensive review guide is organized by domain areas and each subject is addressed according to the degree it is covered on the NBCOT examination. Corresponding workbook pages include specific references to occupational therapy curricula, enabling additional exploration of content that is challenging or unfamiliar. The companion CD ROM simulates online testing with multiple choice practice questions, each providing evidence-based rationale for why a particular answer is correct or incorrect. The CD ROM includes over 100 test questions, case studies, and work sheets.

An Introductory Guide to EC Competition Law and Practice

Valentine Korah,1994 *A Guide to Management and Supervision in Nursing Homes* Sarah Burger,Brenda H. Sullivan Miller,Brenda Fay Mauney,1986 *Physicians Fee & Coding Guide* ,2011 *Guide to U.S. Government Publications* Donna Batten,2006-09

Principles and Practice of Hospital Medicine, Second Edition Sylvia C. McKean,John J. Ross,Daniel D. Dressler,Danielle Scheurer,2016-10-22 The leading textbook of hospital medicine completely updated to reflect today's challenges A Doody's Core Title for 2021 Since its publication in 2012 *Principles and Practice of Hospital Medicine* Second Edition has become the field's premier resource Comprehensive, authoritative, and practical, this landmark text provides a solid grounding in clinical, organizational, and administrative areas central to the practice of hospital medicine. The Second Edition has been completely updated to reflect the evolving practice responsibilities of hospitalists. Examples include value-based medicine, expanded surgical content, bedside clinical reasoning, and a new segment devoted to rehabilitation and skilled nursing care. This edition also features a more accessible and streamlined full color design enriched by more than 600 illustrations. Each clinical chapter opens with boxed Key Clinical Questions that are addressed in the text and summarized in hundreds of tables. Case studies demonstrate how to apply this information specifically to the management of hospitalized patients. Representing the expertise of more than two hundred renowned contributors, *Principles and Practice of Hospital Medicine* Second Edition is logically divided into six sections: The Specialty of Hospital Medicine, and Systems of Care, Medical Consultation, Rehabilitation, and Skilled Nursing Care, The Approach to the Patient at the Bedside, Diagnostic Testing, and Procedures, Clinical Conditions in the Inpatient Setting. *Principles and Practice of Hospital Medicine* Second Edition is essential reading for clinicians who strive to optimize inpatient care and sharpen their leadership skills

Guide to U.S. Government Publications Thomson Gale,2005-08 **California Elder Law** ,2002 **Management Information Guide**

,1970 **Communicating Clinical Decision-Making Through Documentation: Coding, Payment, and Patient Categorization** Eric Shamus,Debra F. Stern,William F. McGehee,2021-02-01 Publisher's Note: Products purchased from Third Party sellers are not guaranteed by the publisher for quality, authenticity, or access to any online entitlements included with the product. Clear, concise, and simple to follow, everything you need to master the documentation process quickly and easily. *Communicating Clinical Decision Making Through Documentation* is the top choice for professionals and students seeking complete coverage of the documentation process, including billing and coding. It shows how to ensure every service rendered and billed is supported by showing what to document, how to do it, and why it is so important. This text includes a refreshing, student friendly approach to the topic. You will find an abundance of cases portraying real life case scenarios and it delivers must know information on writing patient/client care notes incorporating document guidelines, documenting clinical decision making, includes evidence based practice and performing billing and coding tasks. With *Communicating Clinical Decision Making Through Documentation* you'll effectively maintain and organize records, record appropriate information and receive proper payment based on the documentation content. A to Z coverage of physical therapy

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