Medicare Nursing Documentation Guidelines

Long-Term Care Medicine: A Pocket Guide lessens the uncertainty involved in caring for patients in a long-term care facility. This practical pocket guide is divided into four sections: Introduction, Common Clinical Conditions, Psychosocial Aspects, and Special Issues in Long-Term Care. The chapters address all the varied components of the LTC system as well as how to take care of the patients and residents living within it. The contributors to this easy-to-read guide are passionate about LTC and many have worked within the American Medical Directors Association to create and disseminate a knowledge base for practitioners. Long-Term Care Medicine: A Pocket Guide is an invaluable resource for clinicians, practitioners, and educators who are seeking to optimize the care and living experience of residents in LTC by providing resident-centered care as well as resident choice, well-being, dignity, and an improved quality of life.

Better patient management starts with better documentation! Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy, 3rd Edition shows how to accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings, and is based on the International Classification for Functioning, Disability, and Health (ICF) model - the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies - especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook/textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas.

The Future of Nursing explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the health care work force. They also spend the greatest amount of time in delivering patient care as a profession. Nurses therefore have valuable insights and unique abilities to contribute as partners with other health care professionals in improving the quality and safety of care as envisioned in the Affordable Care Act (ACA) enacted this year. Nurses should be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States. To ensure its members are well-prepared, the profession should institute residency training for nurses, increase the percentage of nurses who attain a bachelor's degree to 80 percent by 2020, and double the number who pursue doctorates. Furthermore, regulatory and institutional obstacles -- including limits on nurses' scope of practice -- should be removed so that the health system can reap the full benefit of nurses' training, skills, and knowledge in patient care. In this book, the Institute of Medicine makes recommendations for an action-oriented blueprint for the future of nursing.

Hospice & Palliative Care Handbook, Third Edition, offers concise, focused coverage of all aspects of hospice and palliative care for clinicians, managers, and other team members who provide important care while meeting difficult multilevel regulations. Author Tina M. Marrelli, Director of the first U.S. hospice program to attain Joint Commission accreditation for hospice services, helps caregivers meet quality, coverage, and reimbursement requirements in daily practice and documentation. Filled with key topics such as professional standards and guidelines, bereavement services considerations, outcomes, and goals, and quality control, this comprehensible book provides the tools hospice caregivers need for success. 2nd Place 2018 AJN Book of the Year

Skillmasters

Conditions of Participation for Hospitals

Clinical Documentation Strategies for Home Health

Documentation Guidelines for Evaluation and Management Services

Documentation

Elizabeth I. Gonzalez, RN, BSN Are you looking for training assistance to help your homecare staff enhance their patient assessment documentation skills? Look no further than "Clinical Documentation Strategies for Home Health. " This go-to resource features home health clinical documentation strategies to help agencies provide quality patient care and easily achieve regulatory compliance by: Efficiently and effectively training staff to perform proper patient assessment documentation Helping nurses and clinicians understand the importance of accurate documentation to motivate improvement efforts Reducing reimbursement issues and liability risks to address financial and legal concerns This comprehensive resource covers everything homecare providers need to know regarding documentation best practices, including education for staff training, guidance for implementing accurate patient assessment documentation, tips to minimize legal risks, steps to develop foolproof auditing and documentation systems, and assistance with quality assurance and performance improvement (QAPI) management. "Clinical Documentation Strategies for Home Health" provides: Forms that break down the functions and documentation requirements of the clinical record by "Conditions of Participation," Medicare, and PI activities Tips for coding OASIS Examples of legal issues such as negligence Case studies and advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customized Table of Contents: Key aspects of documentation Defensive documentation: Reduce risk and culpability Contemporary nursing practice Clinical documentation Nursing negligence: Understanding your risks and culpability Improving your documentation Developing a foolproof documentation system Auditing your documentation system Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately

In addition, with the updated HCFA home health agency manual coverage as well as coverage and documentation guidelines, forms may be completed with knowledge of the latest Medicare rules. Best of all, the OASIS-B form, which is hot off the press, is included in its entirety!

Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field.

In addition to reprinting the PDF of the CMS CoPs and Interpretive Guidelines, we include key Survey and Certification memos that CMS has issued to announced changes to the emergency preparedness final rule, fire and smoke door annual testing requirements, survey team composition and investigation of complaints, infection control screenings, and legionella risk reduction.

Nursing & Therapy Documentation in Long-Term Care

Documentation for Rehabilitation - E-Book

St. Anthony's UB-92 Editor (UBE)

Cpt 98 Physicians' Current Procedural Terminology

Handbook of Home Health Standards and Documentation Guidelines for Reimbursement

Complete Guide to Documentation

Nurses are now commonly cited or implicated in medical malpractice cases.

There is a newer version of this book. You are viewing the first edition of this title. Check out the second edition for more up to date information. On August 8, 2011, the Centers for Medicare & Medicaid Services released the final ruling and commentary for the new implementation of the MDS changes set to take effect on Oct. 1, 2011. The Reimbursable Therapy Minutes will be the deciding factor in determining whether a Change of Therapy (COT) OMRA (Other Medicare Required Assessment) will be required, if at all. Most of our skilled nursing facilities are using some type of tracking tool for managing the prospective payment system minutes. Some are computerized, while others are still using paper forms. The Change of Therapy (COT) observation week must be scheduled exactly seven days following the previous MDS or observation week. If there has been a change in RUG category, then a Change of Therapy (COT) OMRA must be done and the reimbursement will drop or increase to the new RUG until another change occurs. CMS decided to assume all SNFs should offer seven-day rehab options, so facilities that traditionally offered Monday through Friday services will face immense challenges with the new Change of Therapy (COT) OMRAs. This book has been updated to discuss the new MDS assessment schedule, the allocation of group therapy minutes, the revised student supervision provisions, the End of Therapy (EOT) Other Medicare Required Assessment (OMRA) and new resumption items, and the new PPS assessment- Change of Therapy (COT) OMRA (Other Medicare Required Assessment). The long term care industry has anticipated the new MDS 3.0. RUG IV coding requires the therapist to specifically account for the time captured during the look back period. This book could help occupational therapists, physical therapists and speech therapists understand Medicare standards for subacute care programs to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book to attain maximum reimbursement. A list of commonly used ICD-9 codes is also provided. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided required the skills of a therapist. The Mandated program, Recovery Audit Contractions, recovered 1 billion dollars during their 3 year demonstration project. This book covers establishing medical necessity, refusing to care for a resident, restraints, safety, creating incident reports, supervising assistive personnel and resident privacy. Coding and billing for subacute and long term care settings are also encompassed in this book, along with denial and appeal management, regulatory guidelines for insurers and improving cash flow with denial management strategies. Proper coding and documentation ensures that facilities will keep their money upon a post payment medical record audit.

Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation Barbara Acello, MS, RN and Lynn Riddle Brown, RN, BSN, CRNI, COS-C Initial assessments can be tricky--without proper documentation, home health providers could lose earned income or experience payment delays, and publicly reported quality outcomes affected by poor assessment documentation could negatively impact an agency's reputation. Ensure that no condition or symptom is overlooked and documentation is as accurate as possible with Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation. This indispensable resource provides the ultimate blueprint for accurately assessing patients' symptoms and conditions to ensure regulatory compliance and proper payment. It will help agencies deliver more accurate assessments and thorough documentation, create better care plans and improve patient outcomes, prepare for surveys, and ensure accurate OASIS reporting. All of the book's 75-plus checklists are also available electronically with purchase, facilitating agency-wide use and letting home health clinicians and field staff easily access content no matter where they are. This book will help homecare professionals: Easily refer to checklists, organized by condition, to properly assess a new patient Download and integrate checklists for use in any agency's system Obtain helpful guidance on assessment documentation as it relates to regulatory compliance Appropriately collect data for coding and establish assessment skill proficiency TABLE OF CONTENTS Section 1: Assessment Documentation Guidelines 1.1. Medicare Conditions of Participation 1.2. Determination of Coverage Guidelines 1.3. Summary of Assessment Documentation Requirements 1.4. Assessment Documentation for Admission to Agency 1.5. Case Management and Assessment Documentation 1.6. Assessment Documentation for Discharge Due to Safety or Noncompliance 1.7. Start of Care Documentation Guidelines 1.8. Routine Visit Documentation Guidelines 1.9. Significant Change in Condition Documentation Guidelines 1.10. Transfer Documentation Guidelines 1.11. Resumption of Care Documentation Guidelines 1.12. Recertification Documentation Guidelines 1.13. Discharge Documentation Guidelines Section 2: General Assessment Documentation 2.1. Vital Sign Assessment Documentation 2.2. Pain Assessment Documentation 2.3. Pain Etiology Assessment Documentation 2.4. Change in Condition Assessment Documentation 2.5. Sepsis Assessment Documentation 2.6. Palliative Care Assessment Documentation 2.7. Death of a Patient Assessment Documentation 2.8. Cancer Patient Assessment Documentation Section 3: Neurological Assessment Documentation 3.1. Neurological Assessment Documentation 3.2. Alzheimer's Disease/Dementia Assessment Documentation 3.3. Cerebrovascular Accident (CVA) Assessment Documentation 3.4. Paralysis Assessment Documentation 3.5. 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Weight Loss, Cachexia, and Malnutrition Assessment Documentation Section 14: Psychosocial Assessment Documentation 14.1. Psychosocial Assessment Documentation 14.2. Delirium Assessment Documentation 14.3. Psychotic Disorder Assessment Documentation 14.4. Restraint Assessment Documentation Section 15: Infusion Assessment Documentation 15.1. Implanted Infusion Pump Assessment Documentation 15.2. Infusion Therapy Assessment Documentation 15.3. Vascular Access Device (VAD) Assessment Documentation

As more people live longer, the need for quality long-term care for the elderly will increase dramatically. This volume examines the current system of nursing home regulations, and proposes an overhaul to better provide for those confined to such facilities. It determines the need for regulations, and concludes that the present regulatory system is inadequate, stating that what is needed is not more regulation, but better regulation. This long-anticipated study provides a wealth of useful background information, in-depth study, and discussion for nursing home administrators, students, and teachers in the health care field; professionals involved in caring for the elderly; and geriatric specialists.

Concepts and Application

Better Documentation

Home Health Assessment Criteria

Reference Guide for Medicare Physician & Supplier Billers

Clinical Documentation Improvement Specialist's Handbook

75 Checklists for Skilled Nursing Documentation

"This resource will help you: Align with MDS 3.0 documentation requirements. Coordinate documentation between nurses and therapists to improve resident care. Gain the perspective of nursing or therapy to appreciate their specific approach to skilled services. Reduce your audit risk and strenthen reimbursement claims with comprehensive documentation. Prove medical necessity and need for skilled care by practicing accurate documentation"--P. [4] of cover.

Health Administration

Documentation Guidelines for Evaluation and Management ServicesAmerican Medical Association PressNursing Documentation Made Incredibly EasyLippincott Williams & Wilkins

cs.hlth_prof.gerontol

The CMS Hospital Conditions of Participation and Interpretive Guidelines

Taking Action Against Clinician Burnout

ICD-9-CM Official Guidelines for Coding and Reporting

Long-Term Care Medicine

Skills for Collaboration and Compliance

Documentation in Action

"This text covers conceptual information, leadership skills and current issues and trends. It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care." --Cover.

Designed to meet the needs of both novice and advanced practitioners, the first edition of Legal Nurse Consulting: Principles and Practice established standards and defined the core curriculum of legal nurse consulting. It also guided the development of the certification examination administered by the American Legal Nurse Consultant Certification Board. The extensive revisions and additions in Legal Nurse Consulting: Principles and Practices, Second Edition make this bestselling reference even more indispensable. The most significant change is the inclusion of 15 new chapters, each of which highlights an important aspect of legal nurse consulting practice: Entry into the Specialty Certification Nursing Theory: Applications to Legal Nurse Consulting Elements of Triage for Medical Malpractice Evaluating Nursing Home Cases Principles of Evaluating Personal Injury Cases Common Mechanisms of Injury in Personal Injury Cases ERISA and HMO Litigation The LNC as Case Manager Report Preparation Locating and Working with Expert Witnesses The Role of the LNC in Preparation of Technical Demonstrative Evidence Marketing Growing a Business Business Ethics Legal Nurse Consulting: Principles and Practices, Second Edition presents up-to-date, practical information on consulting in a variety of practice environments and legal areas. Whether you are an in-house LNC or you work independently, this book is your definitive guide to legal nurse consulting.

UB-92 billing and coding requirements are constantly changing. Staying current is essential to ensure fast and accurate payment for all submitted claims. All the information you need for a perfect Medicare UB-92 claim can be found in updatable, easy-to-use format. No other billing manual offers all of these features: current valid CPT/HCPCS and revenue code combinations; complete information for all revenue, condition, occurrence, and value codes and form locators; medical documentation requirements to support home health, skilled nursing, rural health, and other claims; detailed outpatient bill!ng and coding tips.

Tina M. Marrelli's new book, Home Care Nursing: Surviving in an Ever-Changing Care Environment is a practical and comprehensive guidebook written concisely and without jargon or insider acronyms, making the book accessible to anyone whose work is connected to home care nursing services. Designed to provide chapters as stand-alone resources for readers with previous experience seeking updated guidance, Home Care Nursing is also an excellent guide for course or orientation material. Each chapter is packed with practical questions, discussion topics, and additional resources, such as a complete Medicare Benefit Policy for reference. Additionally, offering more than just an overview of the healthcare and home care markets, this book discusses the unique practice setting and environment of home care nursing, the laws regulations, and quality, and how to make the leap into the field, document your home visit, and improve your professional growth and development.

Home Care Nursing: Surviving in an Ever-Changing Care Environment
Medicare coverage of diabetes supplies & services
A Guide for Nurse Managers
Handbook of Home Health Standards E-Book
A Pocket Guide
Quality, Documentation, and Reimbursement

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product.

Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don'ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter's content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans "Nurse Joy" and "Jake" – expert insights on the nursing process and problem-solving That's a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.

This portable reference is a timesaving guide on how to enhance charting skills, avoid legal pitfalls, and ensure that a complete and accurate record is created every time. Reviews fundamental aspects of charting, nursing process, legal and professional requirements, guidelines for developing a solid plan of care, and the variety of charting forms currently in use, including computerized charting. Completed forms show exactly how to document assessment, intervention, and evaluation. Also addresses the specific requirements for charting in acute care, home care, and long-term care and rehabilitation. Appendices include NANDA Taxonomy II, as well as common abbreviations and symbols.

Designed for rapid on-the-job reference, Documentation in Action offers comprehensive, authoritative, practice-oriented, up-to-the-minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties. Need-to-know information is presented in bulleted lists, charts, flow sheets, sidebars, and boxes, with icons and illustrative filled-in samples. Coverage includes documentation for care of patients with various diseases, complications, emergencies, complex procedures, and difficulties involving patients, families, and other health care professionals. Suggestions are given for avoiding legal pitfalls involving telephone orders, medication reactions, patients who refuse care, and much more. A section addresses computerized documentation, HIPAA confidentiality rules, use of PDAs, nursing informatics, and electronic innovations that will soon be universal.

The complete guide for streamlining and improving nursing documentation for virtually every system. Nurses will find instructions for virtually every common and not-so-common charting method. From progress notes to protocols, there is a wealth of easy-to-follow examples throughout the book. Includes JCAHO-approved nursing abbreviations, ANA standards of practive, and JCAHO and Medicare guidelines for nursing documentation.

Leading Change, Advancing Health
A Guide to Clinical Decision Making in Physical Therapy
Applying Medicare's Rules to Clinical Practice
Long-term Care Skilled Services
Handbook of Home Health Standards
Straight to the Point Documentation Guide for LTC/SNF Nurses

Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medial equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist.,/LI>

Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice Avoid common mistakes that compromise compliance and payment Take the mystery out of skilled services and know when to skill a resident based on government regulations, Medicare updates, the MDS 3.0, and proven strategies. "Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice" illustrates the role played by nurses, therapists, and MDS coordinators in the application and documentation of resident care. Don't miss out on the benefits and reimbursement you deserve, as author Elizabeth Malzahn delivers clear, easy-to-understand examples and explanations of the right way to manage the skilled services process. This book will help you: Increase your skilled census and improve your facility's reputation with the support of your entire staff Avoid under- and overpayments from Medicare with easy-to-understand explanations of complex rules and regulations Provide necessary skilled services to each resident through a complete understanding of eligibility requirements Accurately document skilled services using proven, time-saving solutions Properly assess skilled services under the MDS 3.0 Improve communication to increase resident and family satisfaction Reduce audit risk and prove medical necessity through accurate documentation Table of Contents Rules and Regulations Original law - Social Security and Medicare Act CMS publications Manuals Transmittals MLN matters National and local coverage determinations "RAI User's Manual " Hierarchy of oversight CMS-MAC/FI, OIG, GAO, etc. Technical Eligibility for Skilled Services in LTC Eligibility basics Verification of current benefits How enrollment in other programs impacts coverage under traditional Medicare Hospice HMO/managed care/Medicare Advantage Medicaid/Medi-Cal Hospital stay requirement30-Day transfer rule for hospital or SNFUnderstanding benefit periodsCare continuation related to hospitalizationHow does a denial of payment for new admissions impact Medicare SNF admissions?Meeting the Regulatory Guidelines For "Skilled" Services Skilled services defined Regulatory citations and references Clinical skilled services Therapy skilled services Physician certifications and recertificationPresumption of coverageUnderstanding "practical matter" criteria for nursing home placement Impact of a leave of absence on eligibility MDS 3.0 - Assessments, Sections and Selection...Oh My! Brief history of MDS 3.0 Types of MDS assessments The assessment schedule Items to consider Importance of timing Review of each care-related section of the MDS 3.0Proper Communication During the Part A Stay Medicare meeting Timinng Agenda What to discuss for each resident Ending skilled services Notification requirements Discharging Other notification requirements and communicationOther Important Things to Know Medicare myths Consolidated billing Medical review Audience Administrators, CFO/CEOs, directors of nursing, MDS coordinators, directors of rehab, therapy directors, PT/OT/ST, DONs.

Better patient management starts with better documentation! Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy, 3rd Edition shows how to accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings, and is based on the International Classification for Functioning, Disability, and Health (ICF) model — the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies — especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook/textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas.

Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses.

Quality, Compliance, and Reimbursement
Helping Front Office Personnel Navigate Medicare Rules for Part B Claims Processing
Medicare Edition
Home Care Nursing Practice
A Systems Approach to Professional Well-Being
Medical Records and the Law

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!

Improving documentation is no easy task CDI professionals have never had one easy-to-read, inclusive reference to help them implement a CDI program, understand the fundamentals of ICD-9-CM coding, query physicians, and encourage interdepartmental communication. In theory, physicians should document their entire thought process, including ruling conditions in and out. But it's not that simple, and in light of MS-DRGs, it requires significant physician education and retraining. You need a blueprint for success.. Your blueprint has arrived! At last, here is a guide for CDI specialists. The Clinical Documentation Improvement Specialist's Handbook is your essential partner for creating a CDI program, staffing your program, querying physicians, and understanding how documentation affects code selection and data quality As a CDI specialist you need answers now In light of Medicare Severity DRGs (MS-DRG), detailed documentation and accurate capture of complications and comorbidities (CCs) has made the CDI specialist's role more important and more demanding than ever. This handbook will enhance your ability to gather the right information the first time--and every time Author Colleen Garry, RN, BS, has compiled case studies that document best practices and reference several different CDI models so that you can select the one that's right for your hospital's CDI success. In addition, you'll be privy to an executive summary of HCPro's exclusive CDI survey that solicited more than 800 responses. Learn how other hospitals are handling CDI and choosing the model that works best for them. * work with physicians to obtain detailed, appropriate documentation * maintain compliance when performing physician queries * convey return on investment for a CDI program Customizable CD-ROM included Your copy of The Clinical Documentation Improvement Specialist's Handbook includes a CD-ROM loaded with all of the working tools you'll find in the book. Among them

Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book" has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medial equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist.,/LI>

This full-color handbook is a quick-reference guide to all aspects of documentation for every nursing care situation. It covers current documentation systems and formats, including computerized documentation, and features scores of sample filled-in forms and in-text narrative notes illustrating everything from everyday occurrences to emergency situations. Coverage includes timesaving strategies for admission-to-discharge documentation in acute, outpatient, rehabilitation, long-term, and home care environments and special documentation practices for selected clinical specialties: critical care, emergency, perioperative, maternal-neonatal, and psychiatric. The book includes advice on legal safeguards, dangerous abbreviations, and compliance with HIPAA guidelines and JCAHO requirements.

Mastering Documentation
Guidelines and Documentation Requirements for Social Workers in Home Health Care
A Guide For Nursing Home Social Workers
The Home Health Guide to Medicare Service Delivery, 2016 Edition
Improving the Quality of Care in Nursing Homes
Documentation for Rehabilitation

The Home Health Guide to Medicare Service Delivery, 2016 Edition Annette Lee, RN, MS, HCS-D, COS-C Updated to reflect the 2016 home health PPS final rule, and with a fresh format, The Home Health Guide to Medicare Service Delivery, 2016 Edition, offers a one-stop solution for home health professionals looking for answers to their Medicare compliance questions. This book also enables agencies to ensure services are delivered according to current Medicare regulations and helps staff understand how to produce patient care documentation that supports compliance and proper payment. The new format includes a sleeker, cleaner style for easier reference. This manual provides: Quick access to concise, up-to-date CMS regulations and interpretive analyses A go-to resource for anyone in the home health agency, useful for orientation, training, and reference when stumped by a regulatory or operational question An overview of the home health PPS final rule, featuring complete interpretation and compliance guidelines on all PPS regulations An overview of CMS' proposed Conditions of Participation and what they could mean for home health in the future A comprehensive index with frequently consulted sections presented in boldface type for easy use "Nuts and bolts" education--this book takes the most complicated aspects of Medicare healthcare services and explains them in an easy-to-understand way All up-to-date regulatory changes with a focus on the home health PPS final rule. Contents The Basics of Medicare Service Delivery: Presents the fundamentals of Medicare coverage criteria and the Conditions of Participation (CoP). Includes a section dedicated to survey preparation as well as an exploration of proposed CoPs. The Prospective Payment System (PPS): Gives an overview of critical concepts, including the Home Health Resource Group (HHRG), consolidated billing requirements, and clinical issues with an impact on billing. All About the OASIS: Discusses the fundamentals of the OASIS and assessments. Compliance and Care Delivery: Highlights issues related to visits, physician orders, and start of care, recertification, and discharge. Documentation Essentials: Looks at documentation fundamentals, the clinical record, diagnoses, and the plan of care. Includes a section related to the 485 and elements of content.

Principles and Practice, Second Edition
Nursing Documentation Made Incredibly Easy
Billing, Documentation and Ethics for Subacute Rehabilitation and Skilled Nursing Home Facilities
The Future of Nursing

Managing Documentation Risk
The Medicare Handbook