

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. Guideline to be completed by Medicare Nurse, Unit Manager, or other Nursing Supervisor.

REASON FOR SKILLING ON MEDICARE:

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

TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE	TYPE OF SKILLED SERVICE
<input type="checkbox"/> 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>	<input type="checkbox"/> 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. <input type="checkbox"/> Unstable IDDM <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. 	<input type="checkbox"/> 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 it respiratory status. Describe any changes in LOC, anxiety or other mental status changes. Describe each incident of suctioning and any other invasive techniques. Describe resident's overall condition as it respiratory status and any skilled nursing interventions used to aid in comfort and improve overall status.
<input type="checkbox"/> LM, 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) 	<input type="checkbox"/> 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 -- 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 	<input type="checkbox"/> Decubitus Ulceration (Stage III or IV or Multi- II's) <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. Document any interventions implemented re abnormal lab values (i.e. low H&H, low serum albumin, low Fe+ levels, etc) Describe dietary interventions implemented such as increased vitamin C and protein foods offered. At least q week, describe in detail wound measurements, locations and response to treatments.
<input type="checkbox"/> 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. 	<input type="checkbox"/> Straight Catheterization / GU 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) 	

Medicare Charting Guidelines

United States. Congress



Medicare Charting Guidelines:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 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

Home Care Nursing Practice Robyn Rice, 2006-01-01 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 Documentation for Rehabilitation - E-Book Lori Quinn, James Gordon, 2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school and community settings Case examples for a multitude of documentation types include initial evaluations progress notes daily notes letters to insurance companies Medicare documentation and documentation in specialized settings NEW Movement Analysis Linking Activities and Impairments content addresses issues related to diagnosis NEW An eBook version included with print purchase provides access to all the text figures and references with the ability to search customize content make notes and highlights and have content read aloud Updated case examples provide clinical context for patient documentation Revised content including updated terminology from the latest updates to the Guide to Physical Therapist Practice provides the most current information needed to be an effective practitioner Updated references ensure content is current and applicable for today's practice Effective Documentation for Physical Therapy Professionals, Second Edition Eric Shamus, Debra F. Stern, 2011-05-09 Comprehensive textbook for the documentation material required in all Physical Therapy programs Physical Therapy is one of the fastest growing professions in the US if they want to get paid by third parties they need to have a solid understanding of documentation This book covers every

aspect of documentation including reimbursement and billing coding legal issues PT and PTA communication as well as utilization review and quality assurance Market Audience Primary market are the 30 000 PT students based in the US attending 210 programs Secondary market 155 000 clinicians currently practicing The primary market for this book students has grown by 33% since 2003 when the first edition was published About the Book From exercise prescriptions to patient evaluations insurance forms billing and much more Effective Documentation for Physical Therapy Professionals is your best choice for learning when what and how to document Included are every essential aspect of documentation and many sample documents The easy to follow format gives you the professional guidelines codes and methodology you need to provide expert documentation Key Selling Features Includes all aspects of documentation including reimbursement and billing coding legal issues PT PT and PT PTA communication and utilization review quality assurance Sample documentation content forms exercises and questions are provided as appropriate Uses current APTA terminology and all pertinent professional association regulations Includes SOAP guidelines and examples as well as standardized forms and assessment tools The most up to date comprehensive documentation book for Physical Therapy students and practitioners on the market Contains plenty of examples and exercises to provide practical knowledge to users of the text Author Profiles Eric Shamus DPT PhD CSCS has taught national and international continuing education courses on Orthopedics Sports Medicine and Manual Therapy with a focus on documentation and reimbursement He is presently a professor at Florida Gulf Coast University and works at an outpatient orthopedic facility in Fort Lauderdale Debra F Stern PT MSM DBA is an Associate Professor at Nova Southeastern University in Fort Lauderdale FL She serves as a clinical instructor with a focus on geriatrics neuromuscular disorders and also coordinates service learning experiences for the school s PT department She received her BS in Physical Therapy from SUNY Buffalo her MSM from Rollins College and her DBAS at Nova Southeastern

Handbook of Home Health Standards & Documentation Guidelines for Reimbursement T. M. Marrelli, 2001 Everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards is found in this handbook Offers detailed standards and documentation guidelines for each of more than 60 clinical problems including ICD 9 diagnostic codes service skills including the skills of the multidisciplinary health care team factors justifying homebound status and more

Documentation for Rehabilitation Lori Quinn, James Gordon, 2015-12-11 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

Effective Documentation for Physical Therapy Professionals Eric Shamus, Debra Feingold Stern, 2004 This is a comprehensive textbook for the documentation course required in all Physical Therapy programs The textbook incorporates current APTA terminology and covers every aspect of documentation including reimbursement and billing coding legal issues PT and PTA communication as well as utilization review and quality assurance Midwest

Documentation Guidelines for Evaluation and Management Services American Medical Association, 1995

Congressional Record United States. Congress, 1998

Handbook of Home Health Standards Tina M. Marrelli, 2018-02 This 6th edition of this comprehensive handbook provides practical information about complex Medicare and other rules in home care Areas include OASIS considerations possible patient goals outcomes skills based on the assessed patient needs comfort consideration and caregiver considerations All you need to know about care planning Other areas include tips for supporting medical necessity quality and reimbursement and more The Medicare Benefit Policy Manual Chapter 7 Home Health Services is reprinted for easy reference and use

Handbook of Home Health Standards and Documentation Guidelines for Reimbursement T. M. Marrelli, 1994

Physicians Fee & Coding Guide, 2011

Pediatric Acute Care Karin Reuter-Rice, Beth Bolick, 2012 This comprehensive textbook serves both as a reference for the practicing acute care pediatric nurse practitioners and as a resource for the acute care pediatric nurse practitioner in training Further it provides guidelines for the management of a pediatric patient in the emergent care and inpatient settings Ideally targeted at either the master s or doctorate level it functions as a primary textbook in the nursing practice pediatric nurse practitioner acute care curriculum Also included are formatted Standardized Procedures Practice Protocols for the acute care practice setting that can

Effective Documentation for Occupational Therapy Jane D. Acquaviva, 1998

The New Face of Evaluation and Management Kellie Hall, 2025-06-30 Physicians want to care for patients not spend their time documenting in an electronic medical record Physicians are always complaining about the amount of time they spend documenting patient care in support of medical

billing through an evaluation and management coding system E M New guidelines were created to lessen the time a physician provider spends on documentation as many of the mandatory elements are no longer a requirement for calculating a code level Previously an E M evaluation and management note required documentation of history exam and medical decision making with required elements in each component to support a level for payment If an element was missing the level of service was not supported therefore the code was lowered resulting in a lower reimbursement for the physician provider The new guidelines eliminated the requirement of History and Exam as part of the calculation of a code level Yes an appropriate history and exam are required this supports good patient care but when it comes to reimbursement they are no longer part of the picture The overall system is not difficult if time is taken to understand the elements and how they are applied in the documentation Documentation is a word game always has been the authors focus is to show what words to use to lessen the time but still convey the complexity of the patient s condition and how the physician provider determines a treatment plan which includes the risk to the patient to satisfy the Coding guidelines initiated by Medicare and American Medical Association This book evaluates the new guidelines and brings them into prospective so physicians providers coders can easily understand how to document and calculate the level of service for reimbursement This is not a cumbersome book or complicated but straight to the point The main goal of the book is to educate physicians nurses and coders on what documentation is really required and what has just become habit over the last 30 years Documenting Care Frances Talaska Fischbach,1991 University of Wisconsin Milwaukee School of Nursing s comprehensive charting and documentation manual for students and practitioners *Straight to the Point Documentation Guide for LTC/SNF Nurses* Kik 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 **The Essential Guide to Coding in Obstetrics & Gynecology** Acog,2004 **Patient Care Skills** Mary Alice D. Minor,Scott Duesterhaus Minor,2010 This revised edition retains the engaging format and clear accurate readable information that has become its hallmark Comprehensive coverage provides all the information health care professionals need to perform skills related to patient positioning and transfer vital signs aseptic techniques and more Readers will notice the vivid full color photographs within the procedures that facilitate understanding *The Beacon Guide to Medicare Documentation* Diane J. Omdahl,1988

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