Medicare Skilled Nursing Documentation Requirements

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.

2022 Comprehensive manual for the new or experienced Director of Nursing. All the essential information on Staffing, Resident Care, Quality Assurance, MDS Essentials, Nursing Policy and Procedure, Long Term Care Regulations, Survey Protocols. Forms in the book for Nursing budget, Staffing, Scheduling, employee records, Staff Education, Quality Assurance audits, Infection Control. Current with all RAI Manual Updates, PDPM updates, Surveyor Guidelines and Federal Regulatory Changes. Updated Survey Section with F-Tags List, Survey Focus Areas for F-Tag Deficiencies, Federal Regulatory Groups for Long Term Care, Matrix for Providers, and Surveyor’s Entrance Conference Worksheet. Includes FREE MDS Assessment Scheduling Calendar.

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.

An Evidence-based Handbook for Nurses

Home Health Assessment Criteria

Home Care Nursing: Surviving in an Ever-Changing Care Environment

Patient Safety and Quality

Legal Nurse Consulting

Medicare, Skilled Nursing Facility Manual

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. Seizure Assessment Documentation 3.6. Transient Ischemic Attack (TIA) Assessment Documentation Section 4: Respiratory Assessment Documentation 4.1. Respiratory Assessment Documentation 4.2. Chronic Obstructive Pulmonary Disease (COPD) Assessment Documentation 4.3. Pneumonia/Respiratory Infection Assessment Documentation Section 5: Cardiovascular Assessment Documentation 5.1. Cardiovascular Assessment Documentation 5.2. Angina Pectoris Assessment Documentation 5.3. Congestive Heart Failure (CHF) Assessment Documentation 5.4. Coronary Artery Bypass Graft Surgery (CABG) Assessment Documentation 5.5. Coronary Artery Disease (CAD) Assessment Documentation 5.6. Hypertension Assessment Documentation 5.7. Myocardial Infarction Assessment Documentation 5.8. Orthostatic Hypotension Assessment Documentation 5.9. Pacemaker and Defibrillator Assessment Documentation Section 6: Gastrointestinal Assessment Documentation 6.1. Gastrointestinal Assessment Documentation 6.2. Cirrhosis Assessment Documentation 6.3. Crohn's Disease Assessment Documentation 6.4. Hepatitis Assessment Documentation 6.5. Peritonitis, Suspected Assessment Documentation 6.6. Pseudomembranous Colitis Assessment Documentation 6.7. Ulcerative Colitis Assessment Documentation Section 7: Genitourinary Assessment Documentation 7.1. Genitourinary Assessment Documentation 7.2. Acute Renal Failure Assessment Documentation 7.3. Chronic Renal Failure Assessment Documentation 7.4. Urinary Tract Infection (UTI) Assessment Documentation Section 8: Integumentary Assessment Documentation 8.1. Integumentary Assessment Documentation 8.2. Skin Tear Assessment Documentation 8.3. Herpes Zoster Assessment Documentation 8.4. Leg Ulcer Assessment Documentation 8.5. Necrotizing Fasciitis (Streptococcus A) Assessment Documentation 8.6. Pressure Ulcer Assessment Documentation Section 9: Musculoskeletal Assessment Documentation 9.1. Musculoskeletal Assessment Documentation 9.2. Arthritis Assessment Documentation 9.3. Compartment Syndrome Assessment Documentation 9.4. Fall Assessment Documentation 9.5. Fracture Assessment Documentation Section 10: Endocrine Assessment Documentation 10.1. Endocrine Assessment Documentation 10.2. Diabetes Assessment Documentation Section 11: Eyes, Ears, Nose, Throat Assessment Documentation 11.1. Eyes, Ears, Nose, Throat Assessment Documentation 11.2. Dysphagia Assessment Documentation Section 12: Hematologic Assessment Documentation 12.1. Hematologic Assessment Documentation 12.2. Anticoagulant Drug Therapy Assessment Documentation 12.3. Deep Vein Thrombosis (DVT) Assessment Documentation 12.4. HIV Disease and AIDS Assessment Documentation Section 13: Nutritional Assessment Documentation 13.1. Nutritional Assessment Documentation 13.2. Dehydration Assessment Documentation 13.3. Electrolyte Imbalances Assessment Documentation 13.4. 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

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

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>

Taking Action Against Clinician Burnout

Strategies for Covering Nursing Home Residents Under Medicare

The Future of Home Health Care

ICD-10, G Codes, Goal Writing and Ethics for Subacute Rehabilitation and Skilled Nursing Home Facilities

Conditions of Participation for Hospitals

Instructions to Surveyors

"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.

On October 1, 2014 the ICD-9 code sets used to report medical diagnoses and inpatient procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Also, the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g)) published at http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf states that “The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on resident function during the course of therapy services in order to better understand resident condition and outcomes.” This reporting and collection system requires claims for therapy services to include non-payable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, at specified points during treatment, and at the time of discharge. These G-codes and related modifiers are required on specified claims for outpatient therapy services–not just those over the therapy caps. This book can help occupational therapists, physical therapists, and speech therapists understand Medicare standards for subacute care programs that aim to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book.This book has been updated to discuss the new MDS assessment schedule, distinct days of therapy, co-treatment, the allocation of group therapy minutes, the revised student supervision provisions, the EOT (End of Therapy) OMRA (Other Medicare Required Assessment) and new resumption items, and the new PPS assessment-COT (Change of Therapy) OMRA. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided did require the skills of a therapist. This book discusses 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 covered 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.The information provided here in no way represents a guarantee of payment. Benefits for all claims will be based on the resident's eligibility, provisions of the law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and its requirements.

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.

Documenting Care

Documentation for Rehabilitation- E-Book

The Skilled Services Troubleshooter

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

Senior citizens in the 80's

Quality, Documentation, and Reimbursement

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach provides the framework for successful documentation. It is synchronous with Medicare standards as well as the American Physical Therapy Association’s recommendations for defensible documentation. It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper-based and electronic systems. This key resource skillfully explains how to document the interpretation of examination findings so that the medical record accurately reflects the evidence. In addition, the results of consultation with legal experts who specialize in physical therapy claims denials will be shared to provide current, meaningful documentation instruction.

Complete & accurate documentation is one of the essential skills for a physical therapist. This book covers all the fundamentals & includes practice exercises & case studies throughout.

University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners.

Success Principles

Complete Guide to Documentation

Clinical Management of Patients in Subacute and Long-term Care Settings

Understanding Medicare MDS 3.0 for the Rehabilitation Professional

Handbook of Home Health Standards E-Book

hearings before the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, Ninety-sixth Congress, second session, Jan. 7, 1980, Pomona, Calif., and Jan. 9, 1980, Stockton, Calif

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.

Sixth Edition. The resources and forms in this book and on the CD will greatly clarify, simplify, and expedite the resident assessment and scheduling process. Data Collection, Scheduling, PDPM, Skilled Nursing, Care Planning, 22 Skilled Charting Guidelines, 18 Care Area Assessments and Triggers, Quality Assurance, MDS Coordinator Job Description, Submitting Assessments, MDS Reports, Data Collection Tool, MDS Cheat Sheet, Nursing Assistant Care Form, Weekly Work Calendar, Assessment Master Log, Monthly Assessment, MDS Completion Tracking Form, Medicare Services and Utilization Review, Medicare UR Census, PDPM Patient Driven Payment Model, MDS Items Changing Reimbursement, Section V Notes Sample, CAA Module Summary Notes Sample, Quality Measures, Preventing Avoidable Declines, Skin Breakdown Audit, Pain Interview and Assessment, Pain Assessment for Cognitively Impaired, Incident Audit, Falls, Psychotropic Medication Audit, Surveyor Matrix for Providers, and much more. The MDS Coordinator holds one of the key positions in a long term care facility, and works closely with the entire interdisciplinary team. Looking at the broad picture and spectrum of care, she ensures and enhances the quality of care. The reimbursement of the facility depends on the accuracy and consistency of her documentation.

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 Practice

Director of Nursing Book for Long Term Care

Improving the Quality of Care in Nursing Homes

The CMS Hospital Conditions of Participation and Interpretive Guidelines

From Examination to Outcome

Understanding Medicare Mds 3.0 for the Rehabilitation Professional

Ensure confident clinical decisions and maximum reimbursement in a variety of practice settings such as acute care, outpatient, home care, and nursing homes with the only systematic approach to documentation for rehabilitation professionals! Revised and expanded, this hands-on textbook/workbook provides a unique framework for maintaining evidence of treatment progress and patient outcomes with a clear, logical progression. Extensive examples and exercises in each chapter reinforce concepts and encourage you to apply what you've learned to realistic practice scenarios. UNIQUE! Combination textbook/workbook format reinforces your understanding and tests your ability to apply concepts through practice exercises. UNIQUE! Systematic approach to documenting functional outcomes provides a practical framework for success in numerous practice settings. Case studies show you how to format goals through realistic client examples. Practice exercises provide valuable experience applying concepts to common clinical problems. Four NEW chapters address additional aspects of documentation that rehabilitation professionals will encounter in practice: Legal aspects of documentation Documentation in pediatrics Payment policy and coding Computerized documentation

Home Health Assessment Criteria75 Checklists for Skilled Nursing DocumentationHcpro, a Division of Blr

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.

A Systems Approach to Professional Well-Being

Applying Medicare's Rules to Clinical Practice

Prospective Payment Systems

Principles and Practice, Second Edition

Federal Register

Communication, the Nursing Process and Documentation Standards

Documentation Manual for Speech Language Pathology is a complete guide to documenting medical speech-Language treatment. It is an easy-to-use resource that includes case histories and sample forms that can be copied and used in practice. Medicare documentation process for hospitals, skilled nursing facilities, and home health rehabilitation agencies is included. Documentation in private practice schools and other settings is also covered.

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.

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.

Billing, Documentation and Ethics for Subacute Rehabilitation and Skilled Nursing Home Facilities

Medicare coverage of diabetes supplies & services

Senior Citizens in the 1980's

How to Document for Proper Medicare Reimbursement

Long-term Care Skilled Services

Documentation Manual for Speech Language Pathology

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.

To reduce your facility's risk of unwanted outcomes and ensure proper Medicare reimbursement for the type and number of skilled services provided, it's essential to submit claims appropriately and in accordance with the Centers for Medicare & Medicaid Services' (CMS) skilled services regulations. Don't miss out on Medicare reimbursement or put your facility at risk for fraudulent penalty charges and monetary recoupment "Long-Term Care Skilled Services: How to Document for Proper Medicare Reimbursement" breaks down CMS' skilled services requirements and explains how facilities can best manage the daily operations that affect skilled coverage and necessary documentation. This book provides information for all staff members who play a role in determining and documenting skilled services and includes: Easy-to-understand explanations of complex CMS rules and regulations regarding skilled services A topic-driven format enabling readers to research specific questions and conveniently and efficiently obtain complete and descriptive answers Examples of documentation for skilled services Guidance to help facilities receive the benefits and reimbursement they deserve Downloadable forms This book will help SNFs: Identify common problems and challenges associated with skilled services and gain a better understanding of how to handle the major pain points Properly assess skilled services under the MDS 3.0 Increase skilled census and improve their facility's reputation with the support of the 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 for proper Medicare reimbursement TABLE OF CONTENTS How to properly document for therapy and skilled nursing services Causes medical necessity denials and potentially subsequent audits Impact and necessity of benefit exhaust claims and no-pay claims Certification/recertification completion Medicare rules and regulations under the MDS 3.0 Strategies to maintain skilled census Relationship to diagnosis coding and usage (e.g., V codes) Communication between therapy and nursing

"Provides primary care providers with information specific to the medical management of acutely ill adult and elder patients with multiple comorbid health problems. It also contains material on advanced directives, end of life care and regulatory and compliance concerns that often affect treatment decisions in these settings. A section on staff education is also included for nurse practitioners who are directing patient care given by both skilled and unskilled staff in subacute and long term care." --Cover.

Physical Therapy Documentation

Data Compendium

Manual of Nursing Home Practice for Psychiatrists

Documentation Guidelines for Evaluation and Management Services

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach

MDS Coordinator's Handbook

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.

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.

Individuals with disabilities, chronic conditions, and functional impairments need a range of services and supports to keep living independently. However, there often is not a strong link between medical care provided in the home and the necessary social services and supports for independent living. Home health agencies and others are rising to the challenges of meeting the needs and demands of these populations to stay at home by exploring alternative models of care and payment approaches, the best use of their workforces, and technologies that can enhance independent living. All of these challenges and opportunities lead to the consideration of how home health care fits into the future health care system overall. On September 30 and October 1, 2014, the Institute of Medicine and the National Research Council convened a public workshop on the future of home health care. The workshop brought together a spectrum of public and private stakeholders and thought leaders to improve understanding of the current role of Medicare home health care in supporting aging in place and in helping high-risk, chronically ill, and disabled Americans receive health care in their communities. Through presentations and discussion, participants explored the evolving role of Medicare home health care in caring for Americans in the future, including how to integrate Medicare home health care into new models for the delivery of care and the future health care marketplace. The workshop also considered the key policy reforms and investments in workforces, technologies, and research needed to leverage the value of home health care to support older Americans, and research priorities that can help clarify the value of home health care. This summary captures important points raised by the individual speakers and workshop participants.

Concepts and Application

The Medicare Handbook

Workshop Summary

Long-Term Care Skilled Services

75 Checklists for Skilled Nursing Documentation

Nursing Documentation Made Incredibly Easy

The third book in the Healthcare Payment Systems series, Prospective Payment Systems examines the various types of prospective payment systems (PPS) used by healthcare providers and third-party payers. Emphasizing the basic elements of PPS, it considers the many variations of payment for hospital inpatient and outpatient services, skilled nursing facilities, home health agencies, long-term hospital care, and rehabilitation facilities along with other providers. The book describes the anatomy of PPS, including cost reports, adjudication features and processes, relative weights, and payment processes. It outlines the features and documentation requirements for Medicare Severity Diagnosis Related Groups (MS-DRGs), the Medicare Ambulatory Payment Classifications (APCs), Medicare HHPPS, Medicare Skilled Nursing Resource Utilization Groups (RUGs), and private third-party payers. Provides a framework for understanding and analyzing the characteristics of any PPS Discusses Medicare prospective payment systems and approaches Includes specific references to helpful resources, both online and in print Facilitates a clear understanding of the complexities related to PPS—covering specific topics at a high level and revisiting similar topics to reinforce understanding Complete with a detailed listing of the acronyms most-commonly used in healthcare coding, billing, and reimbursement, the book includes a series of case studies that illustrate key concepts. It concludes with a discussion of the challenges with PPS—including compliance and overpayment issues—to provide you with the real-world understanding needed to make sense of any PPS.

The skilled services troubleshooter takes the mystery out of skilled services and explains exactly when to skill a resident based on government regulations and proven strategies. Never again will you miss out on the benefits and reimbursement you and your resident deserve because you were unsure about the proper rules.

Hearings Before the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, Ninety-sixth Congress, Second Session, Jan. 7, 1980, Pomona, Calif., and Jan. 9, 1980, Stockton, Calif