



Medicare Documentation Requirements Explained

The documentation requirements for an initial and a subsequent visit may vary from one payor to the next and should be followed per the Medical Review Policy of that payor. In the absence of any other guidelines, use the Medicare guidelines. Medicare's documentation requirements aid in proving medical necessity. These standards are published in most Chiropractic Local Coverage Determinations (LCDs) or Local Coverage Articles (LCAs) from your Medicare Administrative Contractor (MAC). Just as no two patients are the same, documentation varies, too—it must be appropriate for the conditions being treated. This tool strives to clarify the stated requirements.

Initial Visit

Initial visit notes tend to be more robust than daily routine office visits or SOAP notes. An Evaluation and Management (E/M) service is documented in an initial visit and lays the groundwork for the entire course of treatment. An initial visit is any visit that kicks off a new episode of care, whether for a new or returning patient. **Note:** This can include an existing patient presenting with a new condition, an exacerbation, or a new injury.

Medicare's Stated Requirement	What It Means
A detailed patient history that includes: - Symptoms that caused the patient to seek treatment and when the problem started - Description/mechanism of the current injury - Quality, character, frequency, and location of the symptoms - His/her relevant family history and past health history	- Each initial visit, whether a new patient or new episode of active care, must include necessary history components of the E/M service, beyond simple "subjective" - Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs). - With multiple complaints, outline each complaint with details as noted - The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care - There is a clear mechanism of injury, or comments regarding when the condition started. If no clear injury has occurred, rule out accidents, slips, trips and falls and indicate when the pain started. - Update any changes in family and health history, and social history or habits on returning patients, as appropriate
An evaluation of the musculoskeletal & nervous system determined through a physical exam	- The components of PART should be present for all spinal regions in which there is a complaint. If using x-ray to identify the subluxation, include the findings and date of the study. - Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis - Specific segments for primary areas to be treated are clearly indicated - Secondary compensations, or asymptomatic findings are clearly indicated - Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.
A diagnosis (Note: the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation.	- The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes - Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.
A plan for treatment including recommended level of care (duration and frequency of visits); the specific functional treatment goals related to the impacted activities of daily living; and objective measures to evaluate the effectiveness of the treatment.	- Include the expected duration in days/weeks/month for this active episode of care - Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month. - List short-term and long-term goals related to the functional deficits collected in the history section of the note. Ensure they can be easily measured on a visit-to-visit basis. - Indicate what effectiveness measure you plan to use to determine whether the treatment is working. Often, Outcomes Assessment Tools (OATs) are used, and the initial score is recorded with a goal score. This is easily measured at re-evaluation intervals.

Medicare Skilled Nursing Documentation Guidelines

Patricia W. Iyer, MSN, RN, LNCC

A red circular graphic with a gradient, appearing as a partial circle or a thick arc, located to the right of the author's name.

Medicare Skilled Nursing Documentation 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

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

audience of professionals from general psychiatrists nurse practitioners and clinical nurse specialists to primary care physicians and residents *MDS Coordinator Book* LTCs Books,2023-04-07 2024 Edition for MDS v1 19 1 The resources and forms in this book 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 Fundamental of Nursing - Guide - 2024 Akash Tiwari,2024-01-08 **Legal Nurse Consulting** Patricia W. Iyer, MSN, RN, LNCC,2002-11-26 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 Fordney's Medical Insurance and Billing - E-Book Linda M. Smith,2024-08-07 Gain the skills you need to succeed in insurance coding and billing Fordney's Medical Insurance and Billing 17th Edition helps you master the insurance billing specialist's role and responsibilities in areas such as diagnostic coding procedural coding HCPCs coding medical documentation billing and collection Using clear explanations this book covers all types of insurance coverage commonly encountered in hospitals physicians offices and

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

Insurance and Risk Management Strategies for Physicians and Advisors David Edward Marcinko, 2005 This book fulfills its promise as a peerless tool for physicians wanting to make good decisions about the risks they face

Medical Coding and Billing - The Comprehensive Guide VIRUTI SHIVAN, Dive into the world of medical coding and billing with Medical Coding and Billing The Comprehensive Guide This essential resource provides a thorough understanding of the crucial role these fields play in healthcare administration Whether you re a student a healthcare professional or simply interested in the administrative side of healthcare this guide offers comprehensive coverage of the latest coding systems billing procedures and regulatory requirements Written by experts in the field the book navigates through complex coding systems including ICD 10 CPT and HCPCS ensuring you re up to date with current practices Beyond the codes it delves into the practical aspects of billing claims processing and the nuances of insurance Essential topics like compliance ethics and the impact of coding on revenue cycle management are covered in depth This guide also addresses the ever evolving landscape of healthcare legislation providing insights into how these changes affect medical coding and billing Furthermore to ensure a clear focus on content this book does not include images or illustrations for copyright purposes Whether you re aiming for

certification or looking to enhance your professional skills Medical Coding and Billing The Comprehensive Guide is your indispensable resource in mastering the intricacies of this vital healthcare industry role *Restorative Care Nursing for Older Adults* Barbara Resnick, 2004-07-28 The purpose of restorative care nursing is to take an active role in helping older adults maintain their highest level of function thus preventing excess disability This book was written to help formal and informal caregivers and administrators at all levels to understand the basic philosophy of restorative care and be able to develop and implement successful restorative care programs The book provides a complete 6 week education program in restorative care for caregivers many suggestions for suitable activities and practical strategies for motivating both older adults and caregivers to engage in restorative care In addition the book provides an overview of the requirements for restorative care across all settings the necessary documentation and ways in which to complete that documentation

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