



## 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
<p>A <b>detailed patient history</b> that includes:</p> <ul style="list-style-type: none"> <li>Symptoms that caused the patient to seek treatment and when the problem started</li> <li>Description/mechanism of the current injury</li> <li>Quality, character, frequency, and location of the symptoms</li> <li>His/her relevant family history and past health history</li> </ul>	<ul style="list-style-type: none"> <li>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"</li> <li>Identification of specific functional activities that are affected by the condition, including measurable deficits in Activities of Daily Living (ADLs).</li> <li>With multiple complaints, outline each complaint with details as noted</li> <li>The initial visit documentation clearly forms the baseline, foundational visit for the episode of care, detailing why the patient is seeking care</li> <li>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.</li> <li>Update any changes in family and health history, and social history or habits on returning patients, as appropriate</li> </ul>
<p>An <b>evaluation</b> of the musculoskeletal &amp; nervous system determined through a physical exam</p>	<ul style="list-style-type: none"> <li>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.</li> <li>Appropriate orthopedic and neurological test performed to quantify the complaints and justify the diagnosis</li> <li>Specific segments for primary areas to be treated are clearly indicated</li> <li>Secondary compensations, or asymptomatic findings are clearly indicated</li> <li>Include additional body systems or areas that may be affecting, or be affected by, the presenting problem.</li> </ul>
<p>A <b>diagnosis</b> (<b>Note:</b> the primary diagnosis for Medicare must be subluxation) that includes a stated level or that is identified by a term descriptive of subluxation.</p>	<ul style="list-style-type: none"> <li>The medical record contains written diagnoses for each condition/region to be addressed, with or without ICD-10 codes</li> <li>Diagnoses are "coupled" per the Medicare rules, with primary as subluxation (segmental dysfunction) and secondary as the neuromusculoskeletal diagnosis, listed for each spinal region.</li> </ul>
<p>A <b>plan for treatment</b> 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.</p>	<ul style="list-style-type: none"> <li>Include the expected duration in days/weeks/month for this active episode of care</li> <li>Indicate the frequency of visits up to the first re-evaluation or discharge if the episode is expected last less than a month.</li> <li>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.</li> <li>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.</li> </ul>

# Medicare Skilled Nursing Documentation Requirements

**Diana Ballard, Paula DiMeo Grant**



## **Medicare Skilled Nursing Documentation Requirements:**

Clinical Management of Patients in Subacute and Long-term Care Settings Terry Mahan Buttarro, Susan Aznavorian, Karen Dick, 2006-01-01 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     **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     **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

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*Law for Nurse Leaders, Second Edition* Diana Ballard, Paula DiMeo Grant, 2017-09-28 Praise for the First Edition This book is so well written I cannot say enough positive things about the material I have read This is excellent material and should be a stock book in the library of every nurse Helen Gordon DNP MS CNM Assistant Professor Duke School of Nursing One of the most hotly discussed and debated areas of society today health care law carries a host of legal and ethical complexities that nurses and providers must increasingly recognize and factor into their best decision making This convenient and comprehensive reference written by expert nurse attorneys untangles the legal dilemmas often encountered in contemporary nursing practice such as nursing malpractice negligence and liability risk management corporate compliance employment law business law and dispute resolution as they relate to health care law and nursing practice Written with the same no nonsense understandable language of the first edition this revision continues to break down the often complex legalese of health care law and now includes two completely new chapters on the evolving roles of advanced practice nurses and managing disasters and public health emergencies Multiple case studies and legal analyses walk the reader through the varied scenarios nurse leaders will confront with staff and patient related legal issues they will encounter on a regular basis New to the Second Edition Revised to reflect multiple changes in health care law and updated information to the nursing legal arena A new chapter Advanced Practice Nursing covers increasing responsibilities in primary care dynamics of health care reform and changing nursing roles A New chapter Disasters and Public Health Emergencies discusses major laws governing these events and hospital emergency operations plans Key Features Serves as a comprehensive text for undergraduate and graduate programs Includes Objectives Conclusions and Trends and Key Points in each chapter Presents real life cases and interactive features to reinforce learning Addresses business topics and corporate law not typically covered in similar texts Covers nursing malpractice risk management employment law business law corporate compliance and dispute resolution

Law For Nurse Leaders Paula DiMeo Grant, Diana Ballard, 2011-04-06 This book is so well written I cannot say enough positive things about the material I have read so far This is excellent material and should be a stock book in the library of every nurse Helen Gordon CNM MS DNP Assistant Professor Duke School of Nursing An essential source of

legal information and analysis for nurse supervisors managers executives administrators practicing nurses and aspiring nursing leaders educators and students in BSN and advanced degree nursing programs Law for Nurse Leaders is a comprehensive guide to current and emerging law issues questions trends and research It aims to empower readers to understand and deal with pressing legal issues in nursing care Written primarily by nurse attorneys with knowledge and expertise in various aspects of the law this reader friendly text discusses nursing malpractice risk management employment law business law corporate compliance and dispute resolution as they relate to health care law and nursing practices Key features Case studies and analysis of significant cases A section of questions from senior nurse executives managers and educators with corresponding answers from the editors and contributing authors A helpful glossary useful statutory references and citations and key legal research Chapter sidebars and callouts of Key Points on each topic for ease of use

**Professional Issues in Speech-Language Pathology and Audiology, Sixth Edition** Melanie W. Hudson, Mark DeRuiter, 2023-10-06 This sixth edition of Professional Issues in Speech Language Pathology and Audiology is intended to be a primary text for students in speech language pathology and audiology as well as a resource for practitioners providing a comprehensive introduction to contemporary issues that affect these professions and service delivery across settings It aims to provide a better understanding that day to day clinical work as well as personal professional growth and development are influenced by political social educational health care and economic concerns By instilling a big picture view of the profession future clinicians will be more prepared to make informed decisions as they provide services engage in advocacy efforts and plan their careers as audiologists or speech language pathologists The book is divided into four major sections Overview of the Professions Employment Issues Setting Specific Issues and Working Productively The information presented in each section provides the reader with a better understanding and a new perspective on how professional issues have been affected by both internal and external influences in recent years including technological advances demographic shifts globalization and economic factors Chapter authors are recognized subject matter experts providing a blend of both foundational and cutting edge information in areas such as evidence based practice ethics job searching and employment issues interprofessional practice service delivery in health care and education technology cultural competence supervision and leadership Students reading this book will appreciate how the professions have evolved over time while acquiring a sense of where they are right now as they prepare to enter the professional world Each of the topics covered in the book will continue to play important roles in the future of speech language pathology and audiology providing early career professionals with the requisite knowledge to achieve success in any setting New to the Sixth Edition New information on issues related to the COVID 19 pandemic Coverage of recent changes in technology Updates to ASHA certification requirements the Assistants certification program and the 2023 ASHA Code of Ethics New contributors Nicole E Corbin Sandra Liang Gillam Erin E G Lundblom Christine T Matthews Shari Robertson Rachel A Ritter and Jennifer P Taylor Updated list of acronyms used in the

book Key Features Chapters authored by recognized experts in communication sciences and disorders Each chapter begins with an introduction and ends with a summary of key areas Critical Thinking questions for each chapter accessible online Case studies related to child and elder abuse Case studies related to advocacy Please note that ancillary content such as documents audio and video etc may not be included as published in the original print version of this book

**Federal Register**, 1999-10 *Management of Adult Neurogenic Dysphagia* Maggie Lee Huckabee, Cathy A. Pelletier, 1999 Clearly delineates the terminology and practices associated with compensatory versus rehabilitative treatment technique in neurogenic dysphagia Includes comprehensive treatment planning and selection of techniques based on physiologic abnormalities rather than symptomatology Provides in depth discussion of various biofeedback modalities and reviews the challenge of diet modification terminology and standard practices Reviews surgical and pharmacological management of the dysphagia patient TEXTBOOK

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**The Massachusetts register**, 1989-11-10 *Effective Documentation for Occupational Therapy* Jane D. Acquaviva, 1998

*Post-hospital Services*, 1975

**Documenting Functional Outcomes in Physical Therapy** Darlene L. Stewart, Susan H. Abeln, 1993 No matter where you work as a PT you must know how to document your services Proper documentation is essential because the majority of payment for PT services comes from third party payors and proper documentation promotes quality care Count on this vital resource for all the information you need to document your work effectively Case studies clearly demonstrate both appropriate and poor documentation Practical tips help you expedite the claims process and guarantee a successful outcome

**Documentation for Rehabilitation** Lori Quinn, James Gordon (Ed.D.), 2010 In this textbook Quinn and Gordon provide a general approach to documentation that can be adapted to different settings for physical therapy students and professionals They emphasize the concept that clinical reasoning is reflected in documentation and vice versa and that documentation is a framework for clinical decision making They cover

each documentation component and examples and exercises that relate to areas such as rehabilitation women's health health and wellness orthopedics and acute care This edition has been revised and expanded and includes new chapters on payment policy and coding legal aspects pediatrics and computerized documentation and incorporates the International Classification of Functioning Disability and Health model

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