

Medicare Charting Cheat Sheet

A Medicare Charting Cheat Sheet is a quick-reference guide to help healthcare providers accurately document patient encounters, treatments, and outcomes in accordance with Medicare's documentation standards. These sheets often focus on essential information that Medicare reviewers look for, including detailed information about symptoms, medical necessity, interventions, and patient outcomes.

Here's a concise guide covers the types of skilled services and key documentation points to ensure compliance.

Physical and occupational therapy

- Document ADLs (e.g., bed mobility, transfers, ambulation) with the level of assistance required.
- Describe the resident's communication abilities and needs.
- Note any fall incidents, including vitals, pain assessment, and follow-up actions.
- Document insulin administration training and resident's blood sugar management.
- Describe symptoms from fluctuating blood sugar levels and any recent order changes.

Speech therapy

- Record resident's communication methods and support needed.
- Document any speech deficits and compensatory strategies.

Respiratory therapy

- Note respiratory sounds (e.g., wheezes, rales) and rate, rhythm, and quality.
- Document vitals (color, chest pain) and response to treatments like nebulizers or oxygen.
- Record respiratory status changes and any lab or imaging results.

Unstable diabetes (IDDM)

- Document insulin administration training and resident's blood sugar management.
- Describe symptoms from fluctuating blood sugar levels and any recent order changes.

Medication administration (I.M. or I.V.)

- Record medication purpose, administration technique, and observations of effectiveness.
- Monitor for side effects (e.g., IV site infiltration or overload signs).

Urinary tract infections (UTI) / septicemia

- Document antibiotic administration and response.
- Include vitals, input/output, symptoms (e.g., dysuria, urgency), and lab results.

Catheterization and GU complications

- Describe catheter use and sterile technique.
- Document any teaching related to self-care and clinical indicators like UTI symptoms.

Medicare Charting Cheat Sheets

JA Banks



Medicare Charting Cheat Sheets:

Charting Made Incredibly Easy! Springhouse,2002 Part of the Springhouse Incredibly Easy Series TM this Second Edition provides current information about charting in a comprehensible clear fun and concise manner Three sections cover Charting Basics Charting in Contemporary Health Care and Special Topics New features include expanded coverage of computerized documentation and charting specific patient care procedures plus current JCAHO standards both in the text and appendix chapter summaries and a new section with case study questions and answers Amusing graphics and cartoon characters call special attention to important information Entertaining logos throughout the text alert the reader to critical information Thought Pillows identify key features of documentation forms and the glossary defines difficult or often misunderstood terms *Quality Assurance and Performance Improvement* Emmanuel Anene,2012-03-07 This book is intended to aide home health owners administrators and managers in practicing good goal directed and efficient care of their patients It is my intention that if this book is properly put to use by all home health care professionals the home health agencies and their patients will benefit immensely Home Health Care has and will continue to undergo changes The use of qualified staff and the effective management of the agencies by their owners and administrator through knowledge and understanding of home health rules and regulations is key to coping with the changes **MDS Coordinator Book** LTC 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 *Documentation for Rehabilitation- E-Book* Lori Quinn,James Gordon,2009-12-18 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 [Guide to U.S. Government Publications](#) Donna Batten,2006-09 **Guide to U.S. Government Publications** Thomson Gale,2005-08 **Diabetes Care Documentation and Coding** Jerome S. Fischer,2002 **Nursing Homes** ,2007 **Healthcare**

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