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Communicating Clinical Decision Making Through Documentation: Coding, Payment, and Patient Categorization The How-to Guide to Home Health Therapy Documentation *Effective Documentation for Physical Therapy Professionals* **Establishment of a Student Physical Therapy Clinical Education Program at Willard Psychiatric Center** *Legal Aspects of Documenting Patient Care* **Introduction to Physical Therapy for Physical Therapist Assistants** The Mental Health Rehabilitation Workbook Screening Notes Physical Medicine & Rehabilitation Pocket Companion Linking Outpatient Rehabilitation Documentation to the Information Super Highway **Journal of the Association for Physical & Mental Rehabilitation** *Understanding Medicare MDS 3.0 for the Rehabilitation Professional Improving Functional Outcomes in Physical Rehabilitation*

This innovative, easy-to-access, pocket guide of essential assessment and treatment information is the ideal patient-side tool for students and rehabilitation clinicians. It's chocked full of critical information that you are unlikely to memorize, but always need close at hand when treating patients. 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). Proper documentation is critical to your success. Clear the confusion, streamline processes, and ensure accuracy, with Essential Forms for Therapists For a rehab facility, proper documentation is the most critical aspect of financial survival. But

unfortunately, it is an area that causes confusion for clinical and non-clinical staff alike. If therapists do not document properly, they run the risk of improper reimbursement and denials. And even if done properly, documentation can be time-consuming and difficult. Simplify the process and ensure accuracy This book and CD-ROM set features over 100 modifiable forms, including: Therapy registration forms Plan of treatment for outpatient rehabilitation forms Plan of progress forms Therapy daily progress forms Therapy daily notes forms and flow sheets All are designed and tested by experts in the field to ensure that critical information is recorded accurately. Save time and streamline your processes The book is divided into four sections for your convenience: Therapy documentation Managed care Personnel management and human resources Essential CMS And the CD-ROM includes additional sections for job descriptions and performance reviews. These forms can easily be customized to fit individual or clinic needs and are geared toward all therapy staff. Take a look at some of the time-saving forms you'll receive: Inpatient rehab patient assessment instrument Medical necessity documentation form Occupational therapy flow sheet Physical therapy and occupational therapy evaluation Physical therapy daily notes Physical therapy flow sheet Plan of progress for outpatient rehabilitation Plan of treatment for outpatient rehabilitation Rehabilitation therapy registration form Speech language pathology flow sheet Speech therapy evaluation Therapy checklist Therapy discharge Therapy progress report Updated plan of progress for outpatient rehab Advanced beneficiary notice--General Advanced beneficiary notice--Laboratory CORF facility request for certification to participate in Medicare program CORF survey report Fire safety report Fire-smoke zone evaluation worksheet Medicare

reconsideration request form Medicare redetermination request form Notice of denial of medical coverage Notice of denial of payment Who will benefit . . . Physical therapists, occupational therapists, speech-language pathologists, and managers in outpatient facilities, comprehensive outpatient rehabilitation facilities, private practice, hospitals and nursing homes Improve your therapy documentation skills today! This best-selling book has been newly updated to improve therapy documentation immediately. This practical resource is the only product on the market that aids PTs, OTs, and SLPs in honing their documentation skills under OASIS-C and complying with the therapy requirements mandated in the home health PPS rules. Through clear examples, real-life scenarios, and the expertise of author Cindy Krafft, PT, MS, therapists will be able to integrate high-quality documentation processes into effective care management practices. This book will teach you how to: Improve therapy documentation accuracy to ensure payment and compliance Coordinate documentation between therapists and other members of the clinical team to improve patient care Prove medical necessity and need for skilled care by practicing accurate documentation Align documentation with functional reassessment and OASIS-C requirements Prevent missed payment and denials and reduce the risk of an audit Table of Contents: Chapter 1: Welcome to the World of Home Health Chapter 2: Documentation: The "D" Word Chapter 3: Medical Necessity Chapter 4: OASIS: Impact on Therapy Practice Chapter 5: Assessments: The Foundation for Medical Necessity Chapter 6: Goals: Measurable and Meaningful Chapter 7: Planning Care: Putting the Pieces Together Chapter 8: Routine Visits: The Need for Ongoing Therapy Chapter 9:

Reassessments: Home Health Requirements Chapter 10: Tips for Qualified Therapists Chapter 11: Tips for Therapist Assistants Chapter 12: Tips for Reviewers Chapter 13: The Future of Therapy in Home Health The How-To Manual for Rehab Documentation, Third Edition A Complete Guide to Increasing Reimbursement and Reducing Denials Rick Gawenda, PT Up-to-speed with Medicare documentation requirements for 2009 and beyond? Increase cash flow and reduce Medicare claim denials by using strategies provided in the Third Edition of The How-To Manual for Rehab Documentation. Written by national consultant Rick Gawenda, PT. Since our last edition, there have been significant changes to the rules and regulations surrounding documentation in therapy settings. And now that the RACs are underway it is even more important to have accurate and thorough documentation. Mistakes can lead to delayed payments and denials, so how do ensure that you are in compliance with the current guidelines? Make it easy. Order your copy of The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials. Written by author and national consultant Rick Gawenda, PT, of Gawenda Seminars, this book and CD-ROM setfocuses on the clinical aspects of documentation and offers proven methods to strengthen documentation and decrease the frequency of denials. Gawenda encourages b documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes. What's new in the third edition? Clarification of certification and re-certification requirements regarding how long they are valid for and how soon they need to be signed Explanation of delayed certification Tips to write function-based short- and long-term goals Updated examples

of well-written goals Updated payer documentation guidelines for evaluations, progress reports, daily notes, discharge reports, and re-evaluations The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials outlines proper documentation strategies starting from the moment a patient registers and receives treatment to billing for time and services. Gawenda encourages b documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes. This comprehensive book and CD-ROM, helps you: Improve therapy billing through better documentation Prevent denials as a result of better documentation practices Maintain quality assurance through proper documentation Optimize your reimbursement from both Medicare and third-party payers Avoid audits and targeted medical reviews Document care in a more efficient way Take the critical steps to verify therapy benefit coverage prior to a patient's initial visit Support skilled therapy services with inclusion of required documentation Understand Medicare certification and recertification time frames and requirements for all therapy settings Understand and use the most commonly used CPT codes and modifiers in rehabilitation therapy Table of Contents: Chapter 1: The Role of the Registration Staff Registration Basics Benefit Verification Preregistering Chapter 2: Initial Documentation Evaluation Format Documentation Components Evaluation Process Objective Criteria Assessment Documentation Goals POC Documentation Creating a Solid Foundation Chapter 3: Certification and Recertification Physician Referrals Physician Referral Denials Outpatient Therapy Settings Certification and Recertification SNF Part A

Therapy Services Reimbursed Under the Prospective Payment System (PPS) Home Health Agency Part A Therapy Services Chapter 4: Daily Documentation Daily Documentation Documentation Requirements Home Exercise Programs (HEPs) Plan Documentation Chapter 5: Progress Reports, Discharge Reports, and Reevaluations Progress Reports Discharges Reevaluations Chapter 6: Maintenance Therapy What is an FMP? Coverage Criteria Documentation Requirements Billing Cover All Your Bases Chapter 7: Wound Care Under Medicare Discharge Criteria Additional Pointers Appendix A: Navigating the CMS Web site Getting Started Final Word Make it easy to understand CMS' documentation guidelines No need to download and interpret the guidance from the CMS Web site yourself. Author Rick Gawenda, PT, has done the work for you. His documentation practices are sure to help you receive optimal compensation for the services you perform as a therapist. Nearly half of all rehab claim denials are STILL due to improper documentation. Ensure proper documentation for services provided and decrease the frequency of denials. Order The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials today! Partnering for Recovery in Mental Health is a practicalguide for conducting person and family-centered recovery planningwith individuals with serious mental illnesses and their families.It is derived from the authors' extensive experience inarticulating and implementing recovery-oriented practice and hasbeen tested with roughly 3,000 providers who work in the field aswell as with numerous post-graduate trainees in psychology, socialwork, nursing, and psychiatric rehabilitation. It has consistentlyreceived highly

favorable evaluations from health careprofessionals as well as people in recovery from mentalillness. This guide represents a new clinical approach to the planning anddelivery of mental health care. It emerges from the mental healthrecovery movement, and has been developed in the process of theefforts to transform systems of care at the local, regional, andnational levels to a recovery orientation. It will be an extremelyuseful tool for planning care within the context of current healthcare reform efforts and increasingly useful in the future, assystems of care become more person-centered. Consistent with otherpatient-centered care planning approaches, this book adapts thisprocess specifically to meet the needs of persons with seriousmental illnesses and their families. Partnering for Recovery in Mental Health is an invaluableguide for any person involved directly or indirectly in theprovision, monitoring, evaluation, or use of community-based mentalhealth care. 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. The vital clinical information you need. HIPAA-compliant, wipe-free, waterproof, reusable patient assessment tools and worksheets, Davis's Notes are portable, indispensable, pocket-sized tools that students and professionals can refer to for the delivery of safe and effective health care. Organized by life span, Screening Notes is a quick and user-friendly tool for all health-care providers, regardless of practice setting. Screening Notes provides a guide to effective screening for medical pathologies and co-morbidities that may profoundly influence therapeutic management or fall outside the scope of practice. 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. 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 utilizes a practical clinical decision making approach and applies this framework to all aspects of documentation. This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning, Disability, and Health (ICF) model can be integrated with a physical therapist's clinical reasoning process and a physical therapist assistant's skill set to produce successful documentation. Includes content on documentation formations: Initial Evaluations, Re-examination Notes, Daily Notes, Conclusion of the Episode of Care Summaries, Home Exercise Program Reviews all the important issues related to style, types of documentation, and utilization of documentation Covers documentation relevant in different settings (inpatient, home health, skilled nursing facility, outpatient) Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up-to-date information in line with APTA Guidelines for Defensible Documentation, World Health Organization, International Classification of Functioning Disability and Health Mode, and Medicare Reviews electronic documentation, ICD-9, ICD-10, and CPT codes Includes important chapters on

Interprofessional Communication, Legal Aspects, Principles of Measurement This is a step-by-step guide to all procedures performed in subacute, home health, day rehab, long-term care and in-patient facility settings. The text emphasizes the team management of rehabilitative care and gives the interdisciplinary team a unifying resource for sage and effective practice. This Second Edition Of Our Easy-To-Use Reference Takes A Risk Management Approach To Patient Care Documentation. It Shows Clinicians From A Wide Variety Of Disciplines How To Be Objective, Precise, Unambiguous, And Timely When Documenting Treatment-Related Matters. The Content Is Written In Straightforward Lay Language And Includes Sample Documentation Forms. The New Edition Includes Information On Computerized Documentation; Coverage Of Telehealth Issues; Updates On JCAHO, CARF, And NCQA Accreditation; And Documentation Problems Specific To Non-Hospital And Managed Care Settings. Features 14 tabbed sections, covering different settings and systems as well as wellness, lab values, pharmacology, and billing. Helps the student and the practitioner work with patients from assessment through treatment to billing. Covers equipment, techniques, and treatments. Offers valuable insights on business practices - home health - women's health - and wellness. This is a Pageburst digital textbook; 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 This hands-on textbook/workbook teaches readers how to document functional outcomes in a clear, logical progression. Extensive examples and exercises in each chapter highlight the essential points of functional outcomes documentation, designed to help improve client function and reduce disability as well as provide evidence of functional progress for insurance payment and reimbursement. Physical Medicine and Rehabilitation Pocket Companion is designed to meet the day-to-day needs of PM&R residents, practicing physiatrists, and physicians in other specialties seeing rehabilitation patients. Focused solely on clinical care delivery, this handy reference provides the tools necessary to navigate everything from PM&R team coordination to the tailoring of medical management to achieve functional goals. Divided into four sections, the book covers all rehabilitation topics and is packed with practical information useful in daily practice, including disease-specific order sets and tips for managing the wide

range of issues that commonly occur during a patient's rehabilitation. The first section introduces the field of rehabilitation medicine, the second reviews the scope of practice of allied health professionals on the rehabilitation team, the third section discusses rehabilitation topics and practice areas, and the fourth is an extensive Appendix of 24 assessment and rating scales, tables, and algorithms, essential for daily clinical use. Physical Medicine and Rehabilitation Pocket Companion is an indispensible resource that belongs in every white coat pocket. Features of Physical Medicine and Rehabilitation Pocket Companion Include: Conciseness and Clinical Orientation: Presents only the key information needed for optimal case management Comprehensive coverage: All major topics in the field of PM&R are represented Consistent approach: Brief text and bulleted format makes information easy to find Order sets provided for most areas to drive clinical care Medication specifics: Covers medications with specific dosages Appendix collects key scales, tables, and algorithms for immediate access Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Second Edition of Documentation Basics: A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z. 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 Orthopeadics, 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. Health Sciences & Professions Manual for allied health practitioners including physical therapists, physical therapy assistants, occupational therapists and exercise physiologists. This is an excellent resource for the student working on clinical affiliations, and when orienting to the clinical setting on their new job. 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 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. Publisher's Note: Products purchased from Third Party sellers are not guaranteed by the publisher for quality, authenticity, or access to any online entitlements included with the product. Clear, concise, and simple to follow—everything you need to master the documentation process quickly and easily Communicating Clinical Decision Making Through Documentation is the top choice for professionals and

students seeking complete coverage of the documentation process including billing and coding. It shows how to ensure every service rendered and billed is supported by showing what to document, how to do it, and why it is so important. This text includes a refreshing student-friendly approach to the topic. You will find an abundance of cases portraying real-life case scenarios and it delivers must-know information on writing patient/client care notes, incorporating document guidelines, documenting clinical decision making (includes evidence-based practice), and performing billing and coding tasks. With Communicating Clinical Decision Making Through Documentation, you'll effectively maintain and organize records, record appropriate information, and receive proper payment based on the documentation content. A to Z coverage of physical therapy documentation, including: Documentation Standards and Guidelines Medicare Home Health Electronic Medical Records (EMR) International Classification of Functioning (ICF) Model and Application Pediatrics Legal Issue Utilization Review & Management Skilled Nursing Facilities Sample Documentation Content Initial Examination and Evaluation Criteria Continuum of Care Content and Goal Writing Exercises Documentation Aspects of Supervising PTAs Abbreviations Payment ICD-10 and CPT Codes and Application Chapter Review Questions Content Principles A therapy tool to utilize in a mental health therapy practice. It is complete with a biopsychosocial instrument, mental health status form, treatment plan, psychoeducation activities and progress notes. The book provides clear guides on how to perform the vital duties required in obtaining accurate, quality, complete, and specific documentation from the providers so as to reflect the quality of care, severity of

illness and risk of mortality of admitted patients during their encounter to the hospital or inpatient rehab. The book is a "must have" for every CDIS or anyone involved in clinical documentation. The book has current ICD-10-CM/PCS update with pertinent information on the 2018 Official Coding Guidelines for Coding and Reporting, Coding Clinic advice, Pay for Performance, sample queries, various disease processes by MDCs, CDI strategy for success in inpatient rehab, rehab impairment group codes and categories, list of all the surgical and MS-DRGs, and much more. Remember, if it was not documented and documented accurately, it never happened. 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. Rely on this well-organized, concise pocket guide to prepare for the everyday

encounters you'll face in the hospital, rehab facility, nursing home, or home health setting. Quickly access just what you need in any setting with succinct, yet comprehensive guidance on every page. Develop all of the skills you need to write clear, concise, and defensible patient/client care notes using a variety of tools, including SOAP notes. This is the ideal resource for any health care professional needing to learn or improve their skills—with simple, straight forward explanations of the hows and whys of documentation. It also keeps pace with the changes in Physical Therapy practice today, emphasizing the Patient/Client Management and WHO's ICF model. Achieve the best functional outcomes for your patients. Here is a practical, step-by-step guide to understanding the treatment process and selecting the most appropriate interventions for your patients. Superbly illustrated, in-depth coverage shows you how to identify functional deficits, determine what treatments are appropriate, and then implement them to achieve the best functional outcome for your patients. Learn through reading, seeing, and doing. Seventeen case studies in the text correspond to seventeen videotaped case studies with voice-over narration online at FADavis.com. These videos show you how practicing therapists interact with their clients in rehabilitation settings…from sample elements of the initial examination through the interventions to the functional outcomes…to make a difference in patients' lives. The advent of Health Care Reform Act of 2010 heralds the shift from the traditionally paternalistic medical model of providing care to a more patient-oriented, outcome-based intervention that places emphasis on the quality of patient care provided rather than a focus on productivity and cost reimbursement. The current trend among most

outpatient rehabilitation clinics attached to a hospital is the lack of an organized method of documenting services that would reflect patient-centered, outcome-based interventions that are measurable and research-friendly. The goal of this program is to facilitate the adoption of a web-based documentation system for outpatient rehabilitation professionals in order to keep abreast with the recent changes in the healthcare industry. This handy guide gives you the essential orthopedic information you need in class, clinical, and practice. Because communication among health care professionals can mean the difference between patient life and death, clear and effective patient care documentation is as important as the delivery of care itself. The rehabilitation professional faces formidable documentation responsibilities. Patient care documentation created by the rehabilitation professional must be accurate, comprehensive, concise, objective, and timely. In an interdisciplinary health care environment, documentation must also be expeditiously communicated to other professionals on the health care team. Fourth Edition, is the only text to integrate coverage of the legal responsibilities of rehabilitation professionals with basic, essential advice on how to effectively document patient care activities from intake through discharge. This resource thoroughly covers the basics of documentation and includes many exemplars, cases, and forms, as well as a sample abbreviations used in rehabilitation settings. This book covers all the bases from ethics, to practical aspects of patient care documentation, to relevant and salient legal implications and illustrative case examples that will help students excel in practice.

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- Screening Notes
- Physical Medicine Rehabilitation Pocket Companion
- Linking Outpatient Rehabilitation Documentation To The Information Super Highway
- Journal Of The Association For Physical Mental Rehabilitation
- Understanding Medicare MDS 30 For The Rehabilitation Professional
- Improving Functional Outcomes In Physical Rehabilitation