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Hospice Clinical Documentation • Course Objectives: - Successful course participants will learn to: üRecognize common documentation errors. üDiscuss the implications of erroneous, inadequate or untimely documentation. üIdentify methods for improving documentation. Hospice Clinical

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Documentation • Hospice benefit available to ...

Hospice Clinical Documentation

For example, “Chaplain will visit patient next week to further facilitate a legacy project and will continue to assess his and his wife’s needs.” Documentation Example. Here is an example of a bad

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documentation and yet it's common among chaplain documentation. Patient smiled and greeted chaplain upon arrival into patient's room.

Five Steps to proper Hospice Chaplain Documentation- For ...

Hospice Documentation . Hospice providers must establish and maintain a

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clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

Hospice Documentation - CGS Medicare

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The following list is a guide for hospice providers and their staff to improve documentation of Medicare covered hospice services by including complete and accurate documentation. This list is intended only as a guide, and is not inclusive, nor does it ensure payment. Remember, the documentation must present a visual picture of the patient,

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Suggestions for Improved Documentation to Support Medicare

...

Inconsistent documentation must be explained and addressed as they occur. Example: Patient with Alzheimers is alert today and able to answer 1-2 word answers. Report by the family states

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that the patient woke up this morning and able to eat breakfast of 2 eggs and 1 piece of toast. This is the most alert the patient has been in >1 month and

HOSPICE DOCUMENTATION: PAINTING THE PICTURE OF THE ...

- A hospice is required to make certain that the physician's clinical judgment

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can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less if the illness runs its normal course

Hospice Documentation for the IDT The Big Picture

When the patient elects hospice, and the physician certifies the patient is

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terminally ill, the patient starts their first hospice benefit period Two 90-day benefit periods Unlimited 60-day periods, as long as the patient continues to be terminal and the physician certifies as such Note: The patient may have had a previous hospice election

Successful Documentation Tips from

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CGS

Hospice Eligibility Documentation Tips and Strategies Page 6 of 7 April 2017. /H P_JA_HospiceEligibilityDocumentationTipsStrategies_20170401/. "Serum album gm/dl on (date) (<2.5) Pre-albumin (<18)" "Taking only sips of fluids" - "drooling", "swallowing difficulty", "chokes easily" "Incontinent of urine &

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feces”, “contractures”, “decubitus ulcer stage 3 or 4” “Episodes of fever & or recurrent after antibiotic tx” “UTI on (date)”, “Septicemia on ...

Hospice Eligibility Documentation Tips and Strategies ...

hospice care or that hospice care is palliative rather than ... s condition was

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appropriate for hospice care . 14 . GIP Documentation • Five recommendations to help ensure that your documentation supports the GIP level of care – Describe the services provided ... • Some examples are frequent changes in the dose or schedule of

Hospice General Inpatient Care

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(GIP)

Hospice Poor Documentation to Support Terminal Prognosis Documentation reviewed for 10/1/2015-10/31/2015 shows: Hospice admission weight was 82.5 lbs. (hospital weight 85 lbs.) Has poor appetite Appears thin, clothes are loose fitting Totally dependent for all ADLs Incontinent of urine and feces

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Nonconversive

Hospice Nursing Documentation: Supporting Terminal Prognosis

I need help, am a new Grad. RN and new to hospice. The problem that am facing is charting. (Neg.- charting) What is Neg.- charting. Can I buy a book to help me with this. I start my new job next

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Monday March 02, 2009. Any advice and or example would be greatly appreciated. Thanks to all who respond.

Hospice charting (Neg- Charting) ? - Hospice / Palliative ...

Last Updated on March 27, 2019. When admitting a patient to hospice with a primary terminal diagnosis of

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Alzheimer's disease, your documentation should clearly show the nature and condition causing the hospice admission in addition to, the hospice disease-specific LCD guidelines.

Documenting Hospice Eligibility for Alzheimer's Dementia ...

3.Documentation principles to support

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this level of care 4. What a hospice should have in place to have a successful continuous home care program 5. The audits and monitors to have in place Levels of Care (LOC) Medicare pays the hospice a per diem rate based on one of four levels of care

Continuous Home Care - Hospice

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Fundamentals

hospice is responsible for any required FTF. •The accepting hospice is advised to have the FTF documentation for the benefit period. –Get copies of the prevailing FTF documentation AND physician narrative. 5 Purpose & Content of the FTF ...

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Webinar Handout Template 2018 - Hospice Fundamentals

2. Once the patient is admitted to GIP the hospice team must document each day the continued need for the GIP level of care that identifies the specific symptoms being managed. The documentation should always reflect working towards a lower level of care

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with discharge planning evident from the first day of the GIP admission.

Required Hospice GIP Documentation - Home Care & Hospice ...

face, or any other documentation located between the narrative and the physicians signature. 5. Face-to-Face

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Encounter and Attestation. For recertification's on or after 1/1/2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for ...
Documentation Examples. Samples of

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Hospice Nursing facility and Home and assisted living orders. Commonly used ICD 10 Codes. How to present a patient during IDG. Changing from one Hospice to Another. An easy to use practical and concise workbook for orientation to Hospice Nursing.

Home - Hospice Nursing 101

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Medicare rules and regulations addressing hospice services require the documentation of sufficient “clinical information and other documentation” to support the certification of individuals as having a terminal illness with a life expectancy of 6 or fewer months, if the illness runs its normal course.

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What we will discuss today Painting a Picture of ...

Document measurable objectives such as: Weight/BMI, Abdominal girth, Mid Arm Circumference, Labs (albumin, electrolytes, renal/liver function), food and fluid intake, percent of meals completed, and the patient's signs and symptoms and how it has changed over

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time.

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