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.

Impaired cognition/behavioral health

- Record symptoms and behavior changes, and document treatment responses.
- Include skin and circulatory condition, lab results, and family expectations.

Constipation and colostomy care

- Document symptoms (e.g., nausea, vomiting, distension) and GI sounds.
- Describe colostomy condition and signs of infection or adverse effects.

Wound care (surgical/lesions/burns)

- Record wound location, pain, and interventions.
- Describe drainage, erythema, and any preventive measures for further complications.

Dialysis/renal failure

- Document medication effects, vitals, and dialysis details.
- Note symptoms (e.g., edema, nausea, skin discolorations) and monitor for adverse signs.

Cardiac issues/bleeding precautions

- Record heart rate, rhythm, edema, chest pain, and lung sounds.
- Monitor weight changes and note any bleeding precautions or INR results.

Decubitus ulcers

- Describe wound condition, treatments, and preventive measures.
- Document dietary interventions and overall skin condition.

Nursing rehabilitation

- Record outcomes for insulin, colostomy, catheter care, wound, and medication training.
- Note bowel and bladder training results and other self-care training outcomes.

Terminal care

- Monitor vitals, I&O, pain management, and response to orders.
- Document skin integrity, family support, and mental status changes.

Gastrostomy tube feeding

- Record fluid/feeding amounts and tolerance (e.g., signs of distension or abnormal lung sounds).
- Describe ostomy site condition and any clinical necessity for tube feeding.

Medically complex conditions

- Document critical symptoms (e.g., fever, dehydration, anemia) and response to skilled care.
- Monitor specific treatments (e.g., radiation therapy, circulatory issues) and complications.

Fractures

- Record pain management, ADL assistance, MD orders, skin checks, and cast care.
- Include vitals, hydration status, and any mental status changes.

Simplifying documentation requirements

Patients over paperwork initiative

Medicare is dedicated to simplifying documentation to help providers spend more time with patients and less on paperwork.

Immunosuppressive medication delivery

- **Before:** Delivery was restricted to the patient's residence after hospital discharge.
- **After:** Initial prescriptions can be delivered to alternative locations, including transplant centers or temporary residences.

Home health care documentation updates

- **Before:** Doctors had to write an extra statement specifying the expected duration of home health services during recertification**.**
- **After:** This extra statement is no longer required.

Medical equipment ordering rules (DMEPOS)

- **Before:** Different medical equipment types had varying order requirements.
- **After:** A unified, standardized set of ordering requirements applies to all medical equipment, with a single comprehensive list of items that may have special payment rules.

Ambulance service documentation

- **Before:** There was uncertainty about documentation requirements for non-emergency ambulance transport certification.
- **After:** A dedicated certification form is optional - existing documentation can suffice if it contains the required information More healthcare professionals can now sign certifications, including licensed practical nurses, social workers, and case managers. These are in addition to the previously authorized signers (physician assistants, nurse practitioners, clinical nurse specialists, registered nurses, and discharge planners).

References

Centers for Medicare and Medicaid Services. (2024, September 10). *Simplifying documentation requirements.* https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/simplifying-documentation-requirements

Richter, LTPAC Performance Advisors. (2024). *Medicare daily skilled charting guidelines.* https://resources.richterhc.com/medicare-daily-skilled-charting-guidelines-pdf-download-richter-healthcare-consultants