

2018 Home Health Workshop Series

Winning with Medicare Addendum Pages

Palmetto GBA

1/31/2018

Disclaimer

Disclaimer

The information provided in this handout was current as of January 30, 2018. Any changes or new information superseding the information in this handout will be provided in articles and publications with publication dates after January 30, 2018, posted at www.PalmettoGBA.com/hhh.

Acronyms/Terminologies

A full listing acronyms and terminologies may be found at www.palmettogba.com/hhh.

Acronym	Definition
ADL	Activities of Daily Living
ADR	Additional Documentation Request
BIC	Beneficiary Identification Code
CBR	Comparative Billing Report
CCN	Claim Control Number
CCS	Clinical Classifications Software
CERT	Comprehensive Error Rate Testing (program)
CD	Compact Disc
CMS	Centers for Medicare & Medicaid Services
COD	Charge on Delivery
CPT	Current Procedural Terminology
CR	Change Request
DDE	Direct Data Entry (system)
DME	Durable Medical Equipment
DOS	Date of Service
EDI	Electronic Data Interchange
EOE	End of Episode
F2F	Face-to-Face

Acronyms/Terminologies

FISS	Fiscal Intermediary Standard System
FY/CY	Fiscal Year/Calendar Year
HHA	Home Health Agency
HH PPS	Home Health Prospective Payment System
HIC Number	Health Insurance Claim Number
HIPPS	Health Insurance Prospective Payment System (codes)
HHGM	Home Health Groupings Model
HHRG	Home Health Related Group
HH QRP	Home Health Quality Reporting Program
HHVBP	Home Health Value-Based Purchasing
ID	Identification
JM	Jurisdiction M
LOS	Length of Stay
LUPA	Low Utilization Payment Adjustment
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
Medicare CCN	CMS Certification Number
M/N	Medical Necessity
MR	Medical Review
NEC	Not Elsewhere Classified
NOS	Not Otherwise Specified

Acronyms/Terminologies

NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPWT	Negative Pressure Wound Therapy
OASIS	Outcome and Assessment Information Set
OPPS	Outpatient Prospective Payment System
PCC	Provider Contact Center
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PECOS	Provider Enrollment, Chain & Ownership System
POC	Plan of Care
PTAN	Provider Transaction Access Number
QIES	Quality Improvement Evaluation System
RAP	Request for Anticipated Payment
RN	Registered Nurse
RRB	Railroad Retirement Board
ROA	Reason for Assessment
RTP	Returned to the Provider
SLP	Speech-Language Pathology
SOC	Start of Care
SSN	Social Security Number
SSNRI	Social Security Number Removal Imitative
TBD	To Be Determined
TOB	Type of Bill

Acronyms/Terminologies

TPE	Targeted Probe and Educate
VO	Verbal Order

Documentation Examples

Home on the Range Home Health Services

Physical Therapy Plan of Care

Patient: Tye A. Knott

Date: 11/15/2016

Diagnosis: Diff w/walking

Impairment: List the functional Limitations:

Impaired mobility/transfers Ambulation Decreased functional abilities Potential/actual post-op complications

High risk falls Potential/actual needs for adaptive equipment Potential actual pain

Impaired ROM Strength Other

Short Term Goals:	Expected Completion Date: 12/2/16
Stk. RW's to 3+/5, Sup w/gait	
Tand. w/HBP	
Long Term Goals:	Expected Completion Date: 12/13/16
Stk. RW to 4/5, Tand w/gait	
Tand w/HBP	

ORDERS: Evaluation: <input checked="" type="checkbox"/> PPT <input type="checkbox"/> OT	
Frequency/Duration: 2 wks 4, 1 wks 1	Effective Date: 11/15/16
<input checked="" type="checkbox"/> PPT Evaluation <input checked="" type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Transfer Training <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Balance Training <input checked="" type="checkbox"/> Gait Training	
<input type="checkbox"/> Prosthetic/Orthotic Training <input type="checkbox"/> Pain Management Techniques	
Physical Agents:	
<input checked="" type="checkbox"/> Establish/Upgrade Home Exercise Program <input type="checkbox"/> Teach Fall Risk Reduction Strategies <input type="checkbox"/> Therapeutic Activities	
<input type="checkbox"/> Other:	
EQUIPMENT RECOMMENDATIONS:	
REHAB POTENTIAL: <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor PROGNOSIS: <input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor	
<input checked="" type="checkbox"/> To achieve pre-morbid functional Status <input checked="" type="checkbox"/> To improve functional level <input type="checkbox"/> To manage condition at home	
Discharge Plan: When maximum benefit from home therapy is achieved, or patient is no longer homebound, DC to:	
<input checked="" type="checkbox"/> Self Care <input type="checkbox"/> Family Care <input type="checkbox"/> Physician <input type="checkbox"/> OP <input type="checkbox"/> Hired Care	

Slide 115

Documentation Examples

FACE-TO-FACE ENCOUNTER FOR HOME HEALTH

To be completed by Home Health Certifying Physician

Patient Name: April Showers

Home Health Start of Care (SOC) Date: 08/31/2016

DOB: 06/30/1930

Face-to-Face Encounter must be completed on or after 06/27/2016 (within 90 days prior to SOC Date) or by 09/30/2016 (within 30 days after the soc Date).

Actual Encounter : Date: 9/7 /16 OR Scheduled Date:

I certify that this patient is under my care and I, or a nurse practitioner/physician's assistant working with me, I had a face-to-face encounter that meets the physician face-to-face encounter requirements with this patient

I certify that my clinical findings support that this patient is homebound.

I certify that the encounter with the patient was in whole, or in part, for the documented medical condition, which is the primary reason for home health care.

I certify that based on my findings, the following are medically necessary home health services:

Skilled Nursing Therapy
g

To provide the care/treatments according to the Plan of care that has been established and will be reviewed periodically.

I, Nick O'Tyme, certify that attached documentation/record supports home health certification and clearly indicates why patient is eligible for Home Health.

Physician Name: Nick O'Tyme

Physician Signature *Nick O'Tyme*

Date of Signature: 9/14/2016

Slide 116

Documentation Examples

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE				
1. Patient's HI Claim No. XXXXXXXXXX	2. Start Of Care Date 08/31/2016	3. Certification Period From: 08/31/2016 To: 10/29/2016	4. Medical Record No.	5. Provider No. 000000
6. Patient's Name and Address April Showers 1 Main Street Mayberry USA		7. Provider's Name, Address and Telephone Number A House is not a Home Home health Care 4545 upside down street Anytown USA		
8. Date of Birth	9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)jew (C)hanged DuoNeb 0.5-3mg/3mL, 1 Nebulizer Treatment inhaled by mouth every 6 hours PRN SOB Robitussin 100 mg/5mL, Take 10 mL's by mouth every 6 hours PRN Ultram SO mg oral tablet. 2 tab(s) orally every 6 hours ProAir HFA 90 mcg/inh inhalation aerosol. Inhale 1 puff every 6 hours Cymbalta 60 mg oral delayed release capsule, 1 cap(s) orally once a Day		
11. ICD-9-CM R2689	Principal Diagnosis other abnormalities of gait	Date 08/31/2016		
12. ICD-9-CM	Surgical Procedure	Date		
13. ICD-9-CM R6281 K219 I10	Other Pertinent Diagnoses Muscle weakness (generalized) gastro-esophageal reflux disease without esophagitis Essential hypertension	Date 08/31/2016 08/31/2016 08/31/2016		
14. DME and Supplies SUPPLIES EQUIPMENT:bath bench, nebulizer, wheelchair		15. Safety Measures: Fall precautions/transfer safety, anticoagulation precautions		
16. Nutritional Req. health heart		17. Allergies: codiene		
18.A. Functional Limitations 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input checked="" type="checkbox"/> Bowel/Bladder (incontinence) 6 <input checked="" type="checkbox"/> Endurance A <input checked="" type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech		18.B. Activities Permitted 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input checked="" type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input checked="" type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker 3 <input type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status: 1 <input checked="" type="checkbox"/> Oriented 3 <input type="checkbox"/> Forgetful 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed 6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other				
20. Prognosis: 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent				
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration) Skilled nursing plan/orders: Skilled Nursing frequency and duration 2X q 60 days for initial evaluation and recertification/discharge plus 1 prn for falls and emergent care need therapy orders: PT to evaluate and treat Safety Care Plan/Orders: Skilled Nursing Assessment and Evaluation: Mental, Emotional Status, Ability caregiver,/family to provide care for patient, Medication safety Skilled nursing instructions/teaching: Medication Safety, Emergency Information Abnormality of gait care plan: SN to assess/instruct mobility on bed, followed by ability to sit with support or unsupported, ability to sit up form sleeping				
22. Goals/Rehabilitation Potential/Discharge Plans Safety Goals: Patient will remain safe at home during plan of care, patient/caregiver will verbalize understanding about safety measures within is EOC. patient/caregiver will demonstrate correct safety techniques related to plan of care within EOC				
23. Nurse's Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT	
24. Physician's Name and Address Nick O'Tyme 44 Clock Street Somehweresville, USA		26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		
27. Attending Physician's Signature and Date Signed <i>Nick</i>		28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.		

Form CMS-485 (C-3) (02-04) (Formerly HCFA-485) (Print Aligned)

Slide 117

Documentation Examples

Department of Health and Human Services
Centers for Medicare & Medicaid Services

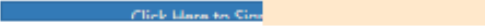
Form Approved
OMB No. 0938-0357

ADDENDUM TO:		<input checked="" type="checkbox"/> PLAN OF TREATMENT		<input type="checkbox"/> MEDICAL UPDATE	
1. Patient's HI Claim No. XXXXXXXXXX	2. SOC Date 08/31/2016	3. Certification Period From: 08/31/2016 To: 10/29/2017		4. Medical Record No.	5. Provider No. 0000000
6. Patient's Name and Address April Showers 1 Main Street Mayberry USA			7. Provider's Name, Address and Telephone Number A House is not a Home Home health Care 4545 upside down street Anytown USA		
8. Item No.					
13	I739 peripheral vascular disease, unspecified 08/31/2016 E				
16	Keep pathways clear, proper use of assistive devices				
21	Orders – continued Position or stand from sitting position Assess/instruct pain should be monitored as it can hinder activity and mobility Assess/instruct when patient is immobile they should be kept in upright position as many times in a day as possible to avoid cardiovascular problems MUSCULOSKELETAL CARE PLAN/INTERVENTIONS/ORDERS: Skilled Nursing Assessment and Evaluation Musculoskeletal, mobility status, safety at home, Physical therapy referral with MD order HOMEBOUND STATUS Requires assistance for most to all ADL, Dependent upon supportive device(s), Unsafe to leave home assisted, Taxing effort to leave home, SOB on exertion, residual weakness				
22	<p>GOALS Patient/caregiver will be knowledgeable about emergency information, emergency preparedness plan within EOC, general goals, for example</p> <p>PHYSICAL THERAPY GOALS Patient's PT goals will be met this certification period Patient will remain safe in the home</p> <p>ABNORMAL GAIT GOALS Client Outcomes Increases physical activity Meets mutually defined goals of increased mobility Verbalizes feeling of increased strength and mobility to move Demonstrates the use of adaptive equipment (e.g. wheelchairs, walkers) to increase mobility</p> <p>MUSCULOSKELETAL GOALS Patient will transfer/ambulate and use assistive devices safely within EOC as evidenced by lack of falls and/or other problems and verbalization of increased stability with ambulation, patient will be safe in their home setting with personal care assistance as evidenced by no injuries/falls during plan of care, patient will reach maximum functional potential within EOC.</p>				
9. Signature of Physician <i>Nick O'Tyner</i>				10. Date 9/22/2016	
11. Optional Name/Signature of Nurse/Therapist				12. Date	

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Slide 118

Documentation Examples

HOME HEALTH CERTIFICATION AND PLAN OF CARE				
1. Patient's HI Claim No. 999999999	2. Start Of Care Date 11-05-2015	3. Certification Period From: 11-05-2015 To: 01-03-2016	4. Medical Record No. 111111111	5. Provider No. 000000
6. Patient's Name and Address Ida Nowe 333 1st Sleet Whoville USA		7. Provider's Name, Address and Telephone Number Home Run Home Care 6622 Third Base Lane Dodger Stadium, USA		
8. Date of Birth	9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged LISINOPRIL-HYDROCHLOROTHIAZIDE,OR,TABS,20-25MG DOSE: 20-25MG ORAL DAILY PRAVASTATIN SODIUM,OR,TABS,20MG DOSE: 20MG ORAL DAILY		
11. ICD S20.01XD	Principal Diagnosis Contusion of right reast, subsequent encou	Date 10-16-2015		
12. ICD	Surgical Procedure	Date		
13. ICD S20.90X D J44.9 110	Other Pertinent Diagnoses Unsp superficial injury of unsp parts of thorax, Chronic l:structive pulmonary disease, unspcified Essential	Date 10-16-2015		
14. DME and Supplies Alcohol wipes, Gloves		15. Safety Measures Fall prevention safety Cont. On 487		
16. Nutritional Req. Regular diet		17. Allergies None Known		
18.A. Functional Limitations		18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 3 <input type="checkbox"/> Contracture 4 <input type="checkbox"/> Hearing 5 <input type="checkbox"/> Paralysis 6 <input type="checkbox"/> Endurance 7 <input type="checkbox"/> Ambulation 8 <input type="checkbox"/> Speech 9 <input type="checkbox"/> Legally Blind A <input type="checkbox"/> Dysphagia With Minimal Caution B <input type="checkbox"/> Other (Specify)		1 <input type="checkbox"/> Complete Bedrest 2 <input type="checkbox"/> Bedrest BRP 3 <input type="checkbox"/> Up As Tolerated 4 <input type="checkbox"/> Transfer Bed/Chair 5 <input type="checkbox"/> Exercise Prescribed 6 <input type="checkbox"/> Partial Weight Bearing 7 <input type="checkbox"/> Independent At Home 8 <input type="checkbox"/> Crutches 9 <input type="checkbox"/> Cane A <input type="checkbox"/> Wheelchair B <input type="checkbox"/> Walker C <input type="checkbox"/> No Restrictions D <input type="checkbox"/> Other (Specify)		
19. Mental Status		1 <input type="checkbox"/> Oriented 2 <input type="checkbox"/> Confused 3 <input type="checkbox"/> Forgetful 4 <input type="checkbox"/> Depressed 5 <input type="checkbox"/> Disoriented 6 <input type="checkbox"/> Lethargic 7 <input type="checkbox"/> Agitated 8 <input type="checkbox"/> Other		
20. Prognosis		1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> Excellent		
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)				
SN: 1W3 EFFECTIVE 11/15/2015 PT: 1W1 EVALUATION EFFECTIVE 11/9/2015 OT: 1W1 EVALUATION EFFECTIVE 11/9/2015 MAY TAKE ORDERS FROM: DR MARK PELSTRING SN ORDERS SN to Instruct Patient/Care giver in the management of the patient's disease management and when to notify the physician SN to evaluate all aspects of pain management every visit SN to instruct patient on pain management SN to instruct patient/caregiver in proper nutrition/hydration to facilitate wound healing SN to monitor vital signs, meds, chest/heart auscultation. SN to instruct. patient in energy conservation techniques. SN to instruct. patient in all aspects of medication regimen inc. schedule dosage, side effects, drug/food interactions. SN TO INSTRUCT ON HOME SAFETY AND FALL PREVENTION CLINICIANS TO MONITOR VS AND REPORT OUT OF THE FOLLOWING PARAMETERS TO Cont. On 487*				
22. Goals/Rehabilitation Potential/Discharge Plans				
Patients symptoms will be well controlled with current therapy within 60 days. Patient will verbalize understanding of disease process, management and intervention and when to notify physician by: 11/26/2015 Patient will be free of pain or pain will not interfere with activity or --***Cont. On 487				
23. Nurse's Signature and Date of Verbal SOC Where Applicable:			25. Date of HHA Received Signed POT	
 <small>Click Here to Sign</small>				
24. Physician's Name and Address			26. I certify/re-certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I ha authorized services on this plan of care and will periodically review the plan.	
Mya Cardium 1122 2nd street Hometown USA				
27. Attending Physician's Signature and Date Signed			28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.	
Mya Cardium 11-02-2015				

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

Documentation Examples

ADDENDUM TO: PLAN OF TREATMENT

1. Patient's HI Claim No. 999999999	2. SOC Date 11/05/2015	3. Certification Period From: 11/05/2015 To: 01/03/2016	4. Medical Record No. 11111111	5. Provider No. 000000
8. Patient's Name Ida Nowe		7. Provider Name Home Run Home care		

8. Item No.

15. Safety Measures:
measures, Direct patient supervision/ Safety in ADL-s, Standard precautions/ Infection control, Bathroom Safety, Medication Safety

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)
MD:BP>180/90<90/50 HR>125<55 T>101<36 RR>24<10
MAY OBTAIN SPO2 AT ADMISSION VISIT AND AS NEEDED FOR SOB, REPORT <90%
LPN may see patient under supervision of RN. Call RN for problems and/ or questions. Notify MD for vital signs outside of set parameters.

22. Goals/Rehabilitation Potential/Discharge Plans
movement by: 11/26/2015.
Patient, Caregiver will be knowledgeable in pain management techniques and verbalize decreased pain from 7 to 3 on pain scale by 60 days.
Wounds will remain free of any signs of infection this certification period. Patient will be knowledgeable in all aspects of cardiac medication/physical regime within 21 days.
Patient will not exhibit signs and symptoms of shortness of breath when walking up to 20 feet or climbing stairs 21 days.
Patient will demonstrate knowledge and compliance in diet by 21 days.
Patient will be knowledgeable in all aspects related to medication administration by the end of 21 days.
Patient will be instructed on safety measures specific to patient environment within 14 days
Patient will remain free of falls this certification period. VS will remain within stated parameters this certification period.

REHAB POTENTIAL
Good for partial recovery.

DISCHARGE PLANS
Patient will be discharged to spouse/family care & to follow up with Dr. at scheduled appointment

Mya Cardium

8. Signature of Physician 10. Date

12/02/2015 11:08PM

11. Optional Name/Signature of Nurse/Therapist 12. Date

11/05/2015

Slide 120

Documentation Examples

Patient: Ida Nowe

PREOPERATIVE HISTORY AND PHYSICAL

HISTORY:

Betty is an 85-year-old white female who was involved in a motor vehicle accident. She was apparently a restrained passenger when she was struck, she sustained blunt trauma to her right chest wall and right breast. She developed a hematoma. While she was in the ER, she was hemodynamically stable, but she did develop some substantial swelling of her right breast to the point that they put her right breast in an Ace compression-type wrap. When she stabilized, they tried to get her up to move, but she became dizzy and felt like she could not get up and leave. Her blood pressure was about 90. Her trauma score was 12, so she was a level II trauma. Throughout her stay, her stay has been stable. Her hemoglobin dropped a little bit.

PAST HISTORY:

Positive for hypertension, hypercholesterolemia, history of arthritis,

PREVIOUS SURGERY:

Tonsillectomy.

MEDICATIONS:

Motrin.
Blood pressure pill.
Cholesterol pill.

SOCIAL HISTORY:

She denies tobacco.

REVIEW OF SYSTEMS:

Constitutional Denies headaches and marked weight change.

EYES: Denies blindness or blurred vision.

CARDIOVASCULAR: Denies chest pain, palpitations, and congestive heart failure.

RESPIRATORY Denies productive cough or hemoptysis.

GASTROINTESTINAL: Denies melena, hematochezia, and jaundice.

GENITOURINARY: Denies frequency and dysuria.

Hematologic: Denies syncope and paraplegia.

LYMPHATIC: Denies axillary, inguinal, or supraclavicular adenopathy.

PHYSICAL Examination:

GENERAL APPEARANCE: Otherwise healthy appearing patient in no acute distress. HEENT: Pupils equal, round, and reactive to light, Extraocular muscles intact. There are no oropharyngeal lesions.

NECK: Supple. There are no thyroid masses.

LUNGS: Clear to auscultation and percussion.

CHEST: she has a pretty substantial hematoma involving the right breast, some tenderness to palpation of the right chest wall.

HEART: Regular rate and rhythm without murmurs.

ABDOMEN: Soft. Bowel sounds are active. There are no masses, tenderness, organomegaly, or pulsatile masses.

NEUROLOGICAL: Intact. Grips are equal. Sensation is intact.

EXTREMITIES: Atraumatic. There is no edema.

LYMPHATICS: No obvious lymphadenopathy is discovered.

DATA REVIEW:

CT scan of the Chest with contrast ~~show~~ a large right breast hematoma.

It did not show evidence of active bleeding. No rib fractures. No underlying lung parenchymal changes were noted.

ASSESSMENT AND PLAN:

patient who has blunt trauma to the right chest wall from a seatbelt. She developed some bleeding into the breast, but it seems to be stabilized. She tried to get up and leave, but given the fact that she is 85 years old, she was a little bit unsteady. Therefore, the emergency room doctors called me and were pretty adamant about the fact they wanted me to admit her for ongoing observation, so we did. We plan to do serial exams, serial hemoglobin, chest films, and we will try to keep her breast wrapped with a little support and some compression

Mya Cardium MD 11/3/2015

Slide 121

Documentation Examples

Patient Name: Ida Nowe
Admit Date: 10/16/2015
Discharge Date:
Dictating Physician: Mya Cardium, MD

Discharge Summary

History:

Ida is an 85-year-old female who was driving a car. An ambulance was coming toward her and the car in front of her slammed on brakes pretty quickly and pulled over to the side, but not enough to avoid a collision. When she arrived she had a rather large hematoma on the right breast. They initially wrapped that with an ACE bandage and they were going to let her go home, but when she got up to leave, she was very weak and dizzy and they could just not get her stable or strong enough to be able to leave the emergency room. That being the case, I admitted her. I was concerned also for the fact that last year, she came in with respiratory failure. She had pneumonia, and I did not want her to develop pneumonia given the fact that she had some blunt chest trauma. Also, she seemed to have a pretty substantial amount of bleeding into the chest. Her hospital course was such that she received physical therapy and occupational therapy. She had been able to get up and walk, but she has a hard time going from sitting to standing without assistance, and it was felt like she was not quite safe enough to go home. Therefore, we put in a referral to Home Health. They are agreeing to take her. In addition, during this hospitalization, she did drop her hemoglobin to 7.5. She had a repeat CAT scan in addition to the imaging that was obtained on admission, and this showed that the bleeding was all into her right breast. That being the case, her right breast obviously is swollen and she has a support bra that is working well. She says since she got the blood transfusion, her strength has improved and she is no longer dizzy when she gets up, but she is still a little bit weak.

Her pre-transfusion hemoglobin was 7.6. her post-transfusion was 8.6

DATA REVIEW:

Chest x-ray reveals some stable pulmonary congestion.
CT of abdomen and pelvis showed a large hematoma within the right breast. No other acute abdominal or pelvis findings are noted.
CT of the chest showed some old right-sided fractures, but they did not believe any of the knit fractures were new.

HOSPITAL COURSE:

The patient is now able to tolerate diet. She is able to sit up with physical therapy. She has a difficult time going from sitting to standing and is a little bit unstable in her gait. She has been hemodynamically stable. She has received supplemental oxygen and also respiratory treatments. She was evaluated during this admission by pulmonologist.

DIET:

regular.

WEIGHTBEARING:

As tolerated.

MEDICATIONS:

Reconciled

CONDITION

Stable

DISPOSITION

She will be transferred to Home Health. She has a very supportive family- and a pretty good home situation, but she does live by herself.

Mya Cardium

Slide 122

Documentation Examples

Client Info

Admit Date: 11/05/2015

Diagnosis List:

PHYSICIAN: Mya Cardium	S20.01XD	10/16/2015	Contusion of right breast, subseq-
	S20.90XD	10/16/2015	Unsp superficial injury of unsp.
	J44.9	10/16/2015	Chronic obstructive pulmonary dis
	I10	10/16/2015	Essential (primary) hypertension
	M19.90	10/16/2015	Unspecified osteoarthritis, unsp.
	Z68.33	01/01/2015	Body mass index (BMI) 33.0-33.9,

Admit Condition:

Pt. was referred to OT services following hospitalization with MVA which no discernible functional limitations

ADMIT CONDITION:

(M1017) Changed Medical Regimen Diagnosis (a):

- S20.01XD, Contusion of right breast, subseq
- S20.90XD, Unsp superficial injury of unsp par

(M1030) Therapies the patient receives at home:

- None of the above

(M1200) vision:

- Partially impaired: cannot see medication labels or newspaper, but can see obstacles in path, and the surrounding layout: can count fingers at arm's length

(M1306) Unhealed Pressure Ulcer at Stage II or Higher or designated as 'unstageable':

- No

(M1350) Skin Lesion or Open Wound:

- No

(M1620) Bowel Incontinence Frequency:

- Very rarely or never has bowel incontinence

(M1630) Ostomy for Bowel Elimination:

- Patient does not have an ostomy for bowel elimination

(M1740) Cognitive, behavioral, and psychiatric symptoms:

- None of the above behaviors demonstrated.

(M18001) Grooming:

- Grooming utensils must be placed within reach before able to complete grooming

activities, (M1810) Ability to Dress Upper Body:

- Able to dress upper body without assistance if clothing is laid out or handed to the patient.

(M1820) Ability to Dress Lower Body:

- Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.

(M1830) Bathing:

- Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.

(M1840) Toilet Transferring:

- When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.

(M1850) Transferring:

- Able to transfer with minimal human assistance or with use of an assistive device.

(M1860) Ambulation/Locomotion:

- Able to walk only with the supervision or assistance of another person at all times.

Slide 123

Documentation Examples

Oasis Report

Patient Ida Nowe

Episode: From 11/05/2015 TO 01/03/2016

Patient Type: Medicare

MO Item	Question	Agreed Answer
	Original Answer	
		ad
MI860	Ambulation/Locomotion	
	4 - Cha.irfa.st, unable to ambulate but is able to wheel self independently.	3 - Able to walk only with the supervision or assistance of another person at all times.

Slide 124