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Government notifies rules to relax telecom infra rollout fees, documentation Turn your home into an art gallery this festive ... for backhauling a large amount of data at high throughput, improving ...

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A FORMER chief executive of a major multinational company has been arrested by fraud squad detectives as part of an investigation into theft and deception offences linked to renovation work on his ...

~~Former CEO arrested in probe into 'home improvement' fraud~~
Washington State Crop Improvement Association manager Lauren Port will depart for California at the end of the month. Aaron Jeschke will replace her as manager.

~~Leadership change at Washington Crop Improvement Association~~
As a first-time homebuyer, you probably have many questions about the homebuying process. Sure, you can answer some of your questions — like how much home you can afford or what PMI is — with online ...

~~17 questions to ask your Realtor when buying your first home~~
Issues plaguing the Beitbridge border post between South Africa and Zimbabwe are slowly showing signs of abating. The 10km queue of trucks that on Friday continued to wait to be let in to Zimbabwe ...

~~Beitbridge border situation slowly improving~~
In order to fully apply artificial intelligence technologies to home improvement ... along with all project and asset information, documentation and data being electronic for new projects ...

~~How Will Artificial Intelligence Change Our Living Spaces?~~
Protocols requiring documentation of criteria for antibiotic initiation and reassessment should be integrated into nursing home workflows to improve adherence. Nursing home staff should receive ...

~~How to Improve Nursing Home Antibiotic Stewardship Programs~~
GLOUCESTER COUNTY, Va. - Big changes are underway in Gloucester County. Broadband access is on its way. The approval comes after years of families trying to access reliable Wi-Fi and Internet.

~~Gloucester County sees broadband expansion, 133 homes soon gain access~~
AHFC has allocated $7 million for the G.O. Repair! Program: $7 million from the General Obligation Bonds approved by voters in November 2018. The G.O. Repair! Program seeks to eliminate health and ...

~~Austin Housing Finance Corporation seeks qualified non-profits for $7 million home rehabilitation and accessibility programs~~
Heritage Home Service, the leading full-service residential plumbing, heating, cooling and electric services provider for New Hampshire ...

~~Heritage Home Service and XOi announce partnership renewal, expanding relationship to help contractors meet labor shortage challenges~~
But something about presenting the data firsthand weekly in front of the owner "really hits home where you're at ... This precise CRM documentation allows the dealership to evaluate factors ...

~~5 'nonnegotiables' help Cooper Auto Group stay on track with goals~~
A Goshen house was found unsafe for human habitation and targeted for possible demolition during a meeting of the Goshen Board of Public Works and Safety Monday afternoon.

~~Goshen home deemed unsafe, may be demolished~~
insufficient documentation, duplicate billing, coding errors, and missed deadlines—and provides recommendations for behavioral health organizations to improve their RCM so that they can spend ...

~~Revenue Cycle Management For A More Profitable & Effective Organization — Exclusive White Paper, Sponsored By TenEleven Group & OPEN MINDS~~
Cig International Corporation (OTCMarkets: WCIG), a company focused on identifying and growing top tech companies in emerging markets, today announced that its controlled subsidiary dba, "EZ365" plans ...

~~EZ NFT and Matrix Mortgage Global are Joining Forces to Mint Essential Real Estate Documentation as NFTs~~
Several council members also described learning about child services referrals involving parents who kept kids home because they ... it's "due to lack of documentation demonstrating a ...

~~DC officials anticipate improvement in school virus testing program, detail child services referrals~~
With Sean's role with SAAC, the group aims to bring the student-athlete community together and support initiatives that improve the experience ... The first home meet will see the Hoyas host ...

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 set""focuses 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!

Elizabeth I. Gonzalez, RN, BSN Are you looking for training assistance to help your homecare staff enhance their patient assessment documentation skills? Look no further than "Clinical Documentation Strategies for Home Health. " This go-to resource features home health clinical documentation strategies to help agencies provide quality patient care and easily achieve regulatory compliance by: Efficiently and effectively training staff to perform proper patient assessment documentation Helping nurses and clinicians understand the importance of accurate documentation to motivate improvement efforts Reducing reimbursement issues and liability risks to address financial and legal concerns This comprehensive resource covers everything homecare providers need to know regarding documentation best practices, including education for staff training, guidance for implementing accurate patient assessment documentation, tips to minimize legal risks, steps to develop foolproof auditing and documentation systems, and assistance with quality assurance and performance improvement (QAPI) management. "Clinical Documentation Strategies for Home Health" provides: Forms that break down the functions and documentation requirements of the clinical record by "Conditions of Participation," Medicare, and PI activities Tips for coding OASIS Examples of legal issues such as negligence Case studies and advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customized Table of Contents: Key aspects of documentation Defensive documentation: Reduce risk and culpability Contemporary nursing practice Clinical documentation Nursing negligence: Understanding your risks and culpability Improving your documentation Developing a foolproof documentation system Auditing your documentation system Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately

Improving documentation is no easy task CDI professionals have never had one easy-to-read, inclusive reference to help them implement a CDI program, understand the fundamentals of ICD-9-CM coding, query physicians, and encourage interdepartmental communication. In theory, physicians should document their entire thought process, including ruling conditions in and out. But it's not that simple, and in light of MS-DRGs, it requires significant physician education and retraining. You need a blueprint for success.. Your blueprint has arrived! At last, here is a guide for CDI specialists. The Clinical Documentation Improvement Specialist's Handbook is your essential partner for creating a CDI program, staffing your program, querying physicians, and understanding how documentation affects code selection and data quality As a CDI specialist you need answers now In light of Medicare Severity DRGs (MS-DRG), detailed documentation and accurate capture of complications and comorbidities (CCs) has made the CDI specialist's role more important and more demanding than ever. This handbook will enhance your ability to gather the right information the first time--and every time Author Colleen Garry, RN, BS, has compiled case studies that document best practices and reference several different CDI models so that you can select the one that's right for your hospital's CDI success. In addition, you'll be privy to an executive summary of HCPro's exclusive CDI survey that solicited more than 800 responses. Learn how other hospitals are handling CDI and choosing the model that works best for them. * work with physicians to obtain detailed, appropriate documentation * maintain compliance when performing physician queries * convey return on investment for a CDI program Customizable CD-ROM included Your copy of The Clinical Documentation Improvement Specialist's Handbook includes a CD-ROM loaded with all of the working tools you'll find in the book. Among them

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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

A companion to Business Process Improvement, which revealed the authors methods for improving business performance. The workbook provides the guidelines, strategies, charts, forms, lists, macros for PC use, overviews, and diagrams needed to implement those methods, which have helped companies like IBM, Boeing, and Corning Glass, realize improvements in

productivity. Annotation copyrighted by Book News, Inc., Portland, OR

This portable reference is a timesaving guide on how to enhance charting skills, avoid legal pitfalls, and ensure that a complete and accurate record is created every time. Reviews fundamental aspects of charting, nursing process, legal and professional requirements, guidelines for developing a solid plan of care, and the variety of charting forms currently in use, including computerized charting. Completed forms show exactly how to document assessment, intervention, and evaluation. Also addresses the specific requirements for charting in acute care, home care, and long-term care and rehabilitation. Appendices include NANDA Taxonomy II, as well as common abbreviations and symbols.

Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medial equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist.,/LI>

Software documentation forms the basis for all communication relating to a software project. To be truly effective and usable, it should be based on what needs to be known. Agile Documentation provides sound advice on how to produce lean and lightweight software documentation. It will be welcomed by all project team members who want to cut out the fat from this time consuming task. Guidance given in pattern form, easily digested and cross-referenced, provides solutions to common problems. Straightforward advice will help you to judge: What details should be left in and what left out When communication face-to-face would be better than paper or online How to adapt the documentation process to the requirements of individual projects and build in change How to organise documents and make them easily accessible When to use diagrams rather than text How to choose the right tools and techniques How documentation impacts the customer Better than offering pat answers or prescriptions, this book will help you to understand the elements and processes that can be found repeatedly in good project documentation and which can be shaped and designed to address your individual circumstance. The author uses real-world examples and utilises agile principles to provide an accessible, practical pattern-based guide which shows how to produce necessary and high quality documentation.

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