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Medical Record Documentation For Electroconvulsive

The medical record documentation will provide an explanation of why ECT is prescribed and must meet the conditions stated in the “Indications and Limitations

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of Coverage and/or Medical Necessity”
section of the LCD. Any clinical history
supporting the use of ECT needs to
clearly document the medical
reasonable and

CBG Electroconvulsive Therapy (ECT)

Electroconvulsive therapy involves

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electrodes being applied to the scalp for delivery of a small electrical current that stimulates a generalized cerebral seizure. General anesthesia is required and causes most of the attendant risks of the procedure. ECT is most effective for major depression with psychosis or severe suicidal ideation.

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**REQUIRED CLINICAL
DOCUMENTATION FOR REVIEW**

Medical Records Requirements 24.

MEDICAL RECORDS CHECKLIST 25. ...

Electroconvulsive therapy (depression
and other mental illness treatment using
electric current to the head) Family
psychotherapy (with the patient present
and their treatment is the primary

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purpose) or

Medicare Mental Health - CMS

The medical record should include documentation of the consent process, including the determination of capacity and the discussion of any heightened risks or necessary treatment modifications. (APA pp. 102-104)

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Guidelines: Providers should ensure that a patient is evaluated to determine their capacity to give consent.

Electroconvulsive Therapy Review Guidelines

c. Medical clearance will be obtained for each resident being considered for electroconvulsive therapy. (1) At a

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minimum, the following will be completed: (a) A thorough physical examination including documentation of cognitive assessment, vital signs, dentition, and updated/current medical history; (b) A comprehensive neurological examination;

STATE OF FLORIDA DEPARTMENT OF

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CF OPERATING PROCEDURE ...

Consistent, current and complete documentation in the medical record is an essential component of quality patient care. The following 21 elements reflect a set of commonly accepted standards for medical record documentation. An organization may use these elements to develop standards for

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medical record documentation.

Guidelines for Medical Record Documentation

If there is no record, there must be documentation regarding immunization status (e.g., "Up To Date" (UTD)), stating who reported the status and that a copy was requested for the medical record.

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Preventive Services (for adult patients seen three or more times): Record should indicate preventive services are offered according to defined Adult ...

Medical Records Documentation Guidelines

Medical Records Documentation Title.
Medical Records Documentation. Date.

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2014-12-01. Providers should submit adequate documentation to ensure that claims are supported as billed. For more information, please refer to Complying With Medical Record Documentation Requirements Fact Sheet (PDF) ...

Medical Records Documentation | CMS

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CMS provides guidelines to help ensure every patient's health record contains quality documentation. General principles of medical record documentation for reporting medical and surgical services for Medicare payment include (when applicable to the specific setting/encounter): Medical records should be complete and legible.

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Set Forth the Basics of Good Medical Record Documentation ...

Medical Policies. Medical record documentation should be relevant to the member's medical condition for the service(s) requested and should always include any specific documentation requirements as outlined in the

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coverage section of the applicable medical policy. Standard Medical record documentation may include but is not limited to the ...

Medical Policy Medical Records Documentation Guidelines

Practice Parameter for Use of
Electroconvulsive Therapy With

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Adolescents ABSTRACT

Electroconvulsive therapy (ECT) may be an effective treatment for adolescents with severe mood disorders and other ... the medical record should indicate the reason for noncompliance. "Clinical Guidelines" [CG] are recommendations ... Documentation of previous ...

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**Practice Parameter for Use of
Electroconvulsive Therapy ...**

Electroconvulsive therapy
documentation and policy checklist: In
which medical record document is
electroconvulsive therapy (ECT)
reported? Is the type of ECT and number
of sessions documented in the medical
record? * Unilateral - Single Seizure *

Bookmark File PDF Medical Record Documentation For Electroconvulsive Therapy Unilateral - Multiple Seizures ...

ICD-10-PCS Coding of Significant Procedures: Behavioral ...

A test called an electroencephalogram (EEG) records the electrical activity in your brain. Sudden, increased activity on the EEG signals the beginning of a seizure, followed by a leveling off that

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shows the seizure is over.

Electroconvulsive therapy (ECT) - Mayo Clinic

Consent for ElectroConvulsive Therapy (ECT) Patient Identification Information Original - Medical Record Page 2 of 2 8)

By signing below I agree: • That a provider has explained and answered all

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of my questions related to ECT. • If I have further questions, I have the right to have those questions answered.

**CONSENT DEPARTMENT OF
PSYCHIATRY AND BEHAVIORAL
SCIENCES ...**

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B. MEDICAL RECORDS . A. General Documentation Rules & Guidelines. 1. General - The hospital initiates and maintains a complete and accurate medical record for every individual assessed or treated. (JCAHO IM 6.10 EOP #6; COP 482.24 (b); DOH 115.31 (a); DOH 119.24) The attending practitioner

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will prepare a complete and legible
medical record ...

Sample Medical Records documentation

Chapter 11 Medical Records and
Documentation. STUDY. Flashcards.
Learn. Write. Spell. Test. PLAY. Match.
Gravity. Created by. C_carrillo. Key

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Concepts: Terms in this set (49)

Important information about a patient's medical history and present condition is found in the. Patient's health record.

Chapter 11 Medical Records and Documentation Flashcards ...

Policies reviewed with changes made to medical criteria. Biofeedback for

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Physical Conditions; Electroconvulsive Therapy (ECT) Swing Bed; Policies reviewed with no changes made to medical records. 72 Hour Subcutaneous Continuous Glucose Monitoring (CGM) Autologous Cultured Chondrocytes; Cardiomems; Cochlear Implant; Fractional Flow Reserve CT ...

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Provider manual: Medical Polices

volume of medical record review requests and provider audits. It also helps us review your performance on the quality ... Document all discussions about BMI in the medical record, including documentation of ...

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Outpatient G0410 Community mental

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