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WEBINAR

Documentation Update 2020: Ensuring Compliance (Webinar T7035)

Date: **Tuesday, July 28, 2020**
Time: **9:00 – 11:00 a.m. CT**
Speaker: Sue Dill Calloway

Program Overview

This webinar is a must-attend program for any nurse, physician, or professional working in health care today. Accurate, concise documentation in medical records is the key to preventing claims of fraud and abuse, and is vital if the records are reviewed by the Recovery Audit Contractors (RACs), the Office of Inspector General (OIG), or the Centers for Medicare and Medicaid Services (CMS). Yet many hospitals have seen an increase in documentation problems with the introduction of electronic health records.

Our expert speaker will discuss the importance of documentation to avoid allegations of malpractice, substandard care, accreditation nightmares and denial of reimbursement, and will provide more than 50 recommendations to improve documentation. The presentation will cover key problematic Joint Commission (TJC) and CMS Hospital Conditions of Participation (CoP) requirements. It will also identify issues that must be documented in order to be reimbursed by CMS, as well as avoid allegation of fraud, abuse and improper documentation. It will also review the new Medicare Outpatient Observation Notice (MOON) form for 2020.

This program will also assist in determining the fields that should be present as hospitals amend electronic medical records to capture the elements required by CMS and the Joint Commission, including requirements for protocols, standing orders, and order sets.

Learning Objectives

At the conclusion of this session, participants should be able to:

1. Discuss two recommendations or tips to improve documentation to reduce the risk of liability.
2. Explain what should be documented in the assessment of pain.
3. Describe that TJC has the Record of Care chapter which includes many things that must be documented in the medical record.
4. Explain the CMS requirement that all orders be in writing in the order sheet even if hospitals use approved protocols.

Discuss that both CMS and TJC have standards that require specific documentation of verbal orders.

Target Audience

CNOs, CMOs, nurses, nurse educators, RAC coordinators, quality improvement staff, regulation and accreditation staff, risk management team members, patient safety officers, hospital legal counsel and compliance officers.

Cost

$195 per connection for NHA members. $390 per connection for non-members.

Note: The fee is for one phone line with unlimited participants.

Speaker Bio

Sue Dill Calloway is president of Patient Safety and Healthcare Consulting and Education company, where she focuses on medical legal education, especially Joint Commission and the CMS hospital CoPs regulatory compliance. She also lectures on legal, risk management and patient safety issues. Previously, Sue was a director for risk management and patient safety for the Doctors Company. She was the VP of legal services at a community hospital and served as the privacy officer and the compliance officer. She was also a medical malpractice defense attorney for 10 years and has three nursing degrees in addition to a law degree.

She is a well-known lecturer and the first in the country to be a certified professional in CMS. She has written 102 books and thousands of articles.

The speaker has no real or perceived conflicts of interest that relate to this presentation.