MEDICAL RECORDS COURSE

Course Overview

The Medical Record Documentation course, a collaborative effort between LifeGuard and KSTAR, is a two-day, in-person program designed for physicians to increase their ability to effectively maintain medical records. Maintaining proper medical records reduces risk to the provider, enhances quality of care and assists in meeting compliance standards.

Participants are expected to be onsite for the two-day course. Presentations will utilize various teaching approaches to include pre- and post-testing, lecture, precepted chart review session and skills practice. For credit, participants must be present and actively participate throughout the course. This course has been approved for 16.25 CME hours*

After attending this course, participants will be able to:

- Improve the quality of medical record documentation in his/her respective practice;
- Reduce risk by understanding the legal implications of medical record documentation;
- Understand licensing and medical board requirements specific to medical record documentation;
- Identify documentation pitfalls and traps;
- Improve the use of "E & M" codes for office visits; and
- Utilize an electronic medical record effectively.

Faculty includes professionals with the following expertise:

- Legal
- Medical Board
- Coding
- Electronic Health Records
- Privacy and Security
- Clinical

Faculty

Robert S. Steele, MD, FAAFP, *Medical Director of the KSTAR Program*

Misti Hill Carter, JD, PhD, *Clinical Assistant Professor, Director of Research, Rural & Community Health Institute (RCHI) Clinical Translational Medicine, TAMU College of Medicine*

Marcia A. Lammando, RN, BSN, MHSA, *LifeGuard Program Director, Adjunct Assistant Professor, Texas A&M University, Rural and Community Health Institute, Clinical Transitional Medicine*

Linda Benner, CPC, CPMA, CASCC, COBGC

Peter Yu, PhD, SCJP: KSTAR Security IT via Skype

Design/Methodology

Participants will be expected to be onsite for the two-day course. Presentations will utilize various teaching approaches to include pre- and post-testing, lecture, precepted chart review session and skills practice.

Participants who have been ordered to attend the course by their medical board or employer are required to submit blinded charts prior to the course for analysis. In additional, they must submit charts for analysis at three months and six months post-course. This activity is optional for all other attendees.

Continuing Medical Education

Medical Records Course:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of the Pennsylvania Medical Society and The Foundation. The Pennsylvania Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

*The Pennsylvania Medical Society designates this live activity for a maximum of *16.25 AMA PRA Category 1 Credits™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The planning committee members and faculty to not have any relevant financial relationships to disclose.

Course fee: $1,150/participant. $250 non-refundable (if you cancel before the course). Course is limited to a maximum 20 participants due to the interactive nature of coding exercises and review.

Location

The course will be held at the Pennsylvania Medical Society Headquarters Building, 777 East Park Drive, Harrisburg, PA, 17105.

For more information and to register

www.LifeGuardProgram.com or 717-909-2590.

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MEDICAL RECORDS
COURSE

MEDICAL RECORDS
COURSE AGENDA

DAY 1

Time	Session
8:15 – 8:45 AM	**Registration and Continental Breakfast**
8:45 – 9:15 AM	Welcome & Course Overview
9:15 – 9:30 AM	Pre-Test
9:30 – 10:45 AM	How to Avoid Legal Scrutiny: The Pen vs the Sword • A malpractice attorney presentation • Reviews risks of improper documentation • Provides insights into risk mitigation
10:45 – 11:00 AM	**Break**
11:00 AM – 1:00PM	Documentation Pitfalls, Traps and Opportunities (Part 1) • How and why medical charts get audited • Done from the view of an external auditor • How to avoid penalties and payment denials
1:00 PM	**Lunch**
1:45 – 3:00 PM	Documentation Pitfalls, Traps, and Opportunities (Part 2) • A continuation of the previous presentation
3:00 – 3:30 PM	Coding and Billing Conundrum Workshop • How to make sure documentation is consistent with billing codes • Attendees engage in coding and billing exercises
3:30 – 3:45 PM	**Break**
3:45 – 4:45 PM	Documentation for the Information Age • A review of the electronic medical record (EMR) • Advantages and pitfalls of the EMR • Voice recognition technology: improving but not perfect
4:45 – 5:30 PM	Hands on Documentation Exercises • Overview of the Problem Oriented Medical Record (POMR) • Review of inpatient and outpatient charting guidelines/requirements • View recorded standardized patient encounters, then generate SOAP notes and hospital admission H&Ps based on the videos

DAY 2

Time	Session
7:30 – 8:00 AM	**Continental Breakfast**
8:00 – 9:30 AM	HIPPA: Privacy and Security • Outline of training requirements for covered entities • A review of federal and state requirements • Learn the implications of exchanging health information electronically • Applicable fines and how to mitigate risk
9:30 – 10:30 AM	Cybersecurity and Risk Assessment • Describe the vulnerability of wireless devices • Review of encryption and other security technologies • How to do a risk assessment
10:30 – 10:45 AM	**Break**
10:45 – 11:15 AM	Cyber-Secure: Online Group Exercise • Attendees work through a number of on-line scenarios that address privacy and security concerns in a virtual clinic • Activities reinforce material learned in the course
11:15 – 12:15 PM	Clinical Decision Support Systems (CDSS) • Overview of software programs that can enhance patient care • A review of validity studies done to date • How CDSSs relate to “Meaningful Use”
12:15 – 12:45 PM	**Lunch**
12:45 – 1:45 PM	Pain Management Documentation • A review of state guidelines for documentation of chronic pain
1:45 – 3:45 PM	Chart Review Session (auditing charts from peer review) • Participants rate the quality of documentation in three or more redacted peer review charts (working in small groups) • A Chart Audit Tool will be used to generate a numeric score • The group will discuss scores and compare findings
3:45 – 4:15 PM	Pre-Test Review (done as a group)
4:15 – 4:45 PM	Post-Test
4:45 – 5:30 PM	Final Questions, Course Evaluations, Adjourn

COURSE CONTENT

Pre- and Post-Evaluation
Those required to attend the course will submit redacted charts before the course for review. A summary of the review will be provided at the course. This exercise is optional for those not required to attend.

How to Avoid Legal Scrutiny
Part 1: Risky Business
Lack of proper documentation can lead to poor patient care, impede continuity of care and place the physician and patient at risk. This discussion focuses on the risk of improper documentation and provides insight into risk mitigation.

How to Avoid Legal Scrutiny
Part 2: The Law and the Medical Record
There are specific, defined requirements that should be documented in the medical record. Missing requirements can expose the physician to liability issues, and the ability to withstand a charge audit. This presentation will discuss the legal implications of medical record documentation.

Pitfalls, Traps and Opportunities
External chart auditors review medical record documentation in a manner that justifies the utilization of services. Many times, medical documentation is not consistent with charge codes, which can lead to penalties and denial of payment. This discussion will point out how to review documentation from the eyes of an external auditor or payer.

Coding and Billing Conundrum
One of the greatest challenges for providers is ensuring documentation is consistent with billing codes. This presentation will cover how to determine if documentation supports the billing code. Physicians will engage in various documentation and coding exercises.

HIPAA: Privacy and Security
Information contained in the medical record must follow guidelines imposed by the Health Insurance Portability and Accountability Act (HIPAA). The physician will learn to be cognizant of implications in exchanging information electronically. This discussion will focus on current HIPAA requirements, releasing information to patients and considerations for exchanging information electronically.

Clinical Decision Support
Many electronic health records include clinical decision support (CDS) tools. While CDS tools aid in making the right diagnosis, they must be used appropriately. This discussion will discuss the use of CDS and electronic medical record documentation.

Documentation in the Information Age
While electronic health records (EHR) are meant to be easier, it can be challenging. Some features are set to automatically populate a record. These automatic entries are not always consistent with the patient’s clinical presentation. This discussion will review considerations for electronic record documentation and includes an EHR documentation lab.

Hands-On Exercise
The hands-on exercise will include a review of two taped, standardized patient scenarios with a physician assessment of each patient. The testing physician will write a progress note, problem list and medication list based on the review of the taped sessions.

Post-Assignment
Those required to attend will submit redacted charts at three months and six months after course completion. This activity is optional for those not required to attend the course.