CONSONUS
HEALTHCARE

"Documenting Your Way Through a Resident's Stay"

DESCRIPTION

Proper documentation is critical to resident centered care, service plan development, change of condition and alert charting. It supports skilled reimbursement and the MDS 3.0 process, and survey outcomes. Facilities place themselves at risk for skilled reimbursement audits and potential denial of payment, inaccurate MDS coding, and survey scrutiny and citation.

The objective of this session is to focus on documentation standards required to assure medical necessity for skilled reimbursement. The differences in therapy language compared to nursing language, survey preparedness documentation. Service plan and care plan process related to correlating documentation including medication and treatment management that are all in alignment with proper documentation. In the end, there is a story to tell about each resident through documentation.

OBJECTIVES

1. Attendees will learn documentation standards required to assure medical necessity for skilled reimbursement.
2. Attendees will learn best practices for proper documentation including use of language, Quality Measures, and MDS accuracy to tell the story of each resident.
3. Attendees will learn how to avoid payment denials, inaccurate MDS coding, and survey citations through proper documentation.