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Magnolia MedLink

Linking Physicians and MRHC

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Letter from CEO, Rick Napper

Well, just as we caught our breath after the Joint Commission survey, the Mississippi State Department of Health showed up on our doorstep to complete a three (3) day validation survey as a follow up to the Joint Commission survey. All in all, we did well and we are all proud of the MRHC staff. The area of concern is the building – old & new. The engineering surveyors were very thorough & found several issues that have to be addressed. Once we receive the official report from the survey, we will have 10 days to submit our plan of correction to the state and 45 days to amend the corrections.

On another note, I would like to take this opportunity to address customer satisfaction. As we move toward the challenges of healthcare reform many hospitals and accompanying medical staff face the same struggles dealing with transparency and payment incentives. I feel that we all have the desire to please our customers and your numbers prove it. Is our hospital hospitable? I believe the answer to that question is yes. Your patient satisfaction numbers have continually increased over the past few years. That is phenomenal and indicates that you are dedicated to your patients, their families and friends and also to Magnolia Regional Health Center. Congratulations!

The operational staff recently completed a planning session to look at healthcare reform issues and to attempt gaining a better grasp on forecasting the next several years. The delivery of healthcare services will undergo much transformation in the era of healthcare reform. Positioning Magnolia Regional Health Center with perceptive multi-year strategies and optimistic organizational culture will be the key to adaptation. Improving quality measures, from patient safety to patient satisfaction, will once again be on the forefront of our diagram. We feel that MRHC is in a good position with our updated, state-of the art information technology initiatives, our plan for cultural transformation and our continued focus on patient safety programs.

Again, I encourage all physicians to continue to closely monitor the political environment and maintain close contact with our representatives in Congress. I expect the situation to change frequently and your efforts are needed.

As always thank you for your dedication and service to your patients and our community.

Respectfully,

Rick Napper, CEO

REQUIRED ACTIONS FOR THE JOINT COMMISION

Vice-President, Medical Affairs
Gene Combest, MD

Based on the recent findings of the recent April 2010 Joint Commission Survey, we are required to complete several actions via the med exec committee and the general medical staff. ACTION (1): Review the required elements of a complete order: name, age, weight, date & time, drug name, exact strength or concentration, dose, frequency and route, quantity and duration when applicable, specific instructions for use when applicable & name of prescriber. ACTION (2): Review the requirements for history physicals: the hospital records the patient's medical history & physical examination, including any update in the medical record within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. ACTION (3): Review the requirements for dating and timing all medical record entries & authentication of verbal orders: all patient record entries must be legible, complete, dated, timed & authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies & procedures. The practitioner must separately date & time his/her signature authenticating an entry even though there may already be a date & time on the document, since the latter may not reflect when the entry was authenticated. ACTION (4): Publish article in physician newsletter & post on physician intranet.

Vice-President of Physician Operations, Don Lloyd

If your practice is not prepared for a possible audit, now is the time to prepare.

Prepare your practice for RAC Audits

Recovery Audit Contractor (RAC) is a well known term that has been widely publicized. Under this program CMS is obligated to do everything possible to protect and safeguard against fraud and abuse. The purpose of RAC is to audit Medicare claims and determine where there are opportunities to recover incorrect payments from claims for non-covered service, incorrect coding, and duplicative services. The initial phase of the Medicare Integrity Program has been completed and RAC is operational in all 50 states.

If your practice is not prepared for a possible audit, now is the time to prepare. HIPAA regulations require every practice to periodically review its billing and coding practices. In addition, CMS recommends that practices do internal audits at least on an annual basis. RAC's are likely to look for:

- Billing and coding errors
- Medically unnecessary treatments
- Wrong settings of care
- Excessive number of units billed

To avoid getting in trouble with RAC, you should first educate your staff on the name of the RAC that is responsible for your region. The audit company responsible for our region is called Connolly. Inform your staff to forward any letters from Connolly to you or your office manager. In a lot of practices, requests come in for copies of medical records and many times the staff pays no attention to who is making those requests.

RAC's were not created to get providers who make occasional billing errors. However, if your practice has a systemic Medicare billing issue, it may trigger a RAC audit. For more information on how to prepare your practice for a RAC audit, please contact the TSPO office at 287.6913.

MRHC awarded continuing AOA approval for IM Residency Program

Magnolia Regional Health Center's Internal Medicine Residency Program was awarded continuing approval for four years on April 8, 2010, by the AOA (American Osteopathic Association) Program and Trainee Review Council. "The MRHC medical staff continues to support medical education efforts in our community and the surrounding communities that we serve, stated Gene Combest, M.D., MRHC Vice-President of Medical Affairs. He added, "I am appreciative to my fellow physicians for the integral part they have played in achieving this accreditation."

As the only accrediting agency for osteopathic medical education, the AOA is responsible for developing and enforcing postdoctoral training requirements, policies and procedures in order to ensure the highest quality residency programs. According to MRHC President and CEO, Rick Napper, "We feel that through this program, MRHC will be able to meet the challenging task of recruiting primary care physicians to rural areas of northeast Mississippi." MRHC's residency program is ACOI (American College Osteopathic Internists) approved for Internal Medicine Specialty.

As of July 1, 2010, MRHC will have three residents in their third year of training, four residents in their second year of training and seven residents in their first year of training. Director of Medical Education, David Pizzimenti, D.O., stated, "We are thrilled to have established a thriving osteopathic residency program in northeast Mississippi. It is our hope that the program will continue to grow and contribute to MRHC's ongoing mission of providing the highest quality care to our patients." MRHC's Internal Medicine Residency Program is the only internal medicine approved osteopathic residency in the state of Mississippi.

CMS Tightens Signature Requirements: No Rubber Stamping

Medicare requires that services provided or ordered be authenticated by the author. The method used for authentication may be a handwritten or electronic signature. Rubber-stamp signatures are not acceptable.

All physician documentation must be authenticated, dated and timed. This includes physician orders for outpatient testing.

Verbal orders must be signed within 48 hours, including date and time.

Signatures must be complete and legible. If a signature is illegible, there must be a typed or printed name next to the signature.

Medical Trivia

The world's first human lung transplant was performed at the University of Mississippi Medical Center in Jackson, in 1963. The world's first heart transplant was performed at the Center the following year.

Acinetobacter Threat

My fellow practitioners, acinetobacter baumanii & other variant species or related gram negative nonmotile aerobes are posing an increased threat to the health of our patients. These bacteria are hardy survivalists in the hospital environment & pose a real threat to immunocomprised patients. There have been an increased number of cases of infection with these organisms in the vicinity, if not in Alcorn County. These soil & water organisms are usually no threat to the immunocompetent patient but are being found more commonly in compromised ICU patients. Please consider cultures in any patient that has recently had surgery or hospitalization at another facility including nursing homes & contact isolation of these patients until cultures are negative in patients that have wound infections or drainage allowing for easier transmission of infection. These organisms are relatively resistant to all classes of antibiotics except carbapenems making treatment or existing infections difficult. Further information will be transmitted as available.

Gene Combest, M.D.

Vice-President, Medical Affairs

E-Safety First

STANDARDIZATION OF ORDERS FOR IMPROVED PATIENT OUTCOMES

The Institute for Safe Medication Practices has long been an advocate for the use of standard orders sets to minimize incorrect or incomplete prescribing, standardize patient care, and ensure clarity when communicating medical orders. Now that healthcare providers are forging the path to improving patient care through Computerized Physician Order Entry (CPOE), standard order sets have become the foundation on which CPOE is built. With well-designed order sets and CPOE, MRHC medical staff has the potential to reduce medication errors/ litigation, improve the quality of patient care by communicating best practices, reduce duplication of tests and prescriptions as well as reduce the variation and un-intentional oversight in prescribing that meets the requirements of core measures, improve patient outcomes, standardize care, and speed up the delivery of orders with pertinent instructions that are easily understood and electronically entered.

On the other hand, if standardized order sets are not carefully designed, reviewed, and maintained to reflect best practices and ensure clear communication, they may actually contribute to errors. This is where the medical staff will play a leading role. To ensure that safe order sets are built, MRHC has formed an Order Set Development Team as a branch of the overall Physician Care Manager (PCM) Project and contracted with an outside vendor, Zynx Health, to provide oversight with current evidence based information and regulating organizations' recommendations. Currently, the Order Set Development team is formulating a policy that will address the design, review, approval, and maintenance of standardized order sets (MRHC universal order sets, provider group specific orders, and physician's favorites). The medical staff will be asked to lead development and participate at all levels of the formation of these order sets.

The Order Set Development Team meets every Friday from 0800-1200 as a work group to take existing MRHC order sets, compare them to evidence-based best practices provided by Zynx Health, and develop comprehensive order sets based on the top DRG's identified at Magnolia. Members of the work group reflect experience and input from the medical staff, nursing, pharmacy, surgery, information technology, case management, quality, Joint Commission compliance, health information management, radiology, and respiratory therapy. The goal of the team is to have 80% of all current MRHC order sets based on top DRGs standardized in paper form by September of this year when the software build for CPOE begins. Physicians will then be familiar with these order sets by the time CPOE roll-out begins in April, 2011.

Once these top DRG order sets have been identified, the work begins. After existing order sets have been compared to the Zynx Health information, all departments represented in the order sets will review for accuracy of ordering – Lab, radiology, pharmacy, etc. - thus approving them for presentation to the medical staff. Any order set that will affect all MRHC physicians universally will be approved at medical staff meetings. Specialty driven order sets will be approved by all physicians within that specialty, and physician favorites will be built individually per their preferences.

The order set development team will be utilizing the Institute of Safe Medication Practices' "Guidelines for Standard Order Sets" as a checklist in developing MRHC order sets, and you will no doubt be asked to participate in the process. Please offer your expertise and knowledge in making these order sets something that will be universally accepted and meet the requirements for best practices in our mission to provide safe and efficient delivery of healthcare – "One patient at a time".

How to Perform a Physician Practice Internal Billing Audit

An internal billing audit can help ensure appropriate payment and compliance with applicable laws.

What is a billing audit?

In a prospective billing audit, a designated practice staff person or internal compliance officer reviews the claims before they are submitted to the payer to ensure the appropriateness of the coding, documentation and adherence to health plan medical payment policies.

In a retrospective audit, the designated person reviews claims for appropriateness after they are paid. All overpayments and billing errors identified during a retrospective audit should be handled according to the payer's repayment guidelines.

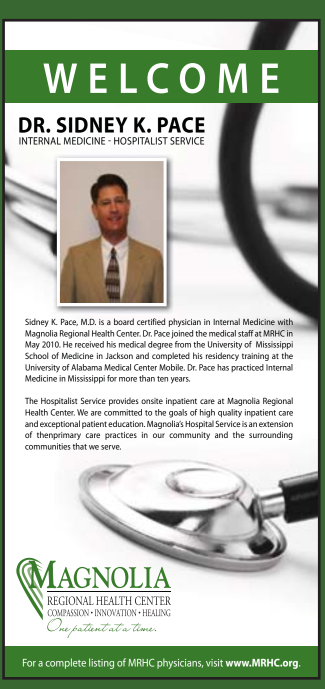
What are the steps to perform a billing audit?

1. Determine who will be responsible for conducting the audit.
2. Address the following:
   - Will the audit be performed retrospectively or prospectively?
   - What type and size of sample will be drawn; random, controlled, select payers, all payers?
   - What audit tools will be used to determine the appropriateness of claims?
   - What risk areas should be closely monitored?

   The OIG recommends auditing five or more medical records per federal payer (i.e., Medicare, Medicaid), or five to 10 random medical records per physician. Additionally, the OIG suggests three methods of drawing a random sample: from paid claims, claims by payer or claims containing one of the top 10 denials by payers.
3. Use a claim analysis checklist to identify the appropriateness of coding, documentation and completeness of a claim. Sample checklist items include:
   - Was the service performed and documented appropriately?
   - Is the correct physician and practice identification numbers listed on the claim?
   - Is each CPT code correct for service performed?
   - Is the appropriate modifier appended to the CPT code to more exactly reflect the service performed?
   - If this medical record was reviewed by an outside auditor who does not know the patient, does the record support the CPT codes selected?
4. The medical record should substantiate that each service provided by the physician was medically necessary and reasonable.
5. Discuss audit findings with physician and staff, as appropriate, and discuss any claims processing issues that can be resolved through staff and physician education. Document the practice's efforts to improve its claims submission process. If the audit reveals a pattern of repeated billing errors, the physician should obtain legal advice from a health law attorney to determine possible consequences.
6. Never stop improving the practice's claims submission and auditing processes.

Renee Bullard, Compliance Officer
ph: 662-293-7673

Welcome Dr. Sidney K. Pace



Graduate Medical Education

Medical Students & Residents:

MRHC recently held a fiesta to celebrate the graduation of our fourth year medical students and to recognize our residents & physicians! These individuals that were recognized demonstrate the values that we stand for in their everyday work. They have become true leaders in our organization through leading by example. These individuals motivate others to perform at their best, leading the entire team toward ultimate success.

Brian Lindsey matched into a General Surgery Residency at Michigan State University/ Oakwood SouthShore Medical Center in Trenton, MI.

Clacy Camel matched into a Psychiatric Residency at University Mississippi Medical Center in Jackson, MS.

Amanda Johnson matched into a Transitional Rotating Internship (with a Radiology focus) at Samaritan Health Hospital in Watertown, New York .

Clinical Documentation Improvement

In progressing forward with the CDI program, the initial stages of implementation will involve meeting / working with you individually. I will be contacting a few of you soon to begin this process and also to determine your preferences for our interactions /review process.

In the meantime, below are a few important points documentation useful in providing a clear, detailed, and specific record of the patient's visit. Thorough documentation also helps reduce the need for retrospective queries!

1. Anemia: specify blood loss anemia (acute or chronic), hemolytic , pernicious, secondary to chronic disease
2. Respiratory Insufficiency or Failure: specify (acute or chronic), secondary to(specify condition)
3. Pnemonia: Is it aspiration, bacterial (specify organism if possible) , community acquired.
4. CHF: specify (acute or chronic) plus systolic or diastolic; if needed, document unknown or NOS (not otherwise specified)
5. Wounds: specify type (ulcer, diabetic, etc.) also (complicated, infected, non-healing)

Remember, documentation should be specific, clearly written, and repeated throughout the medical record. This insures the "story" of the patient is understood by all caregivers. Additionally, it helps the coders who depend on this documentation to provide the information needed to accurately "transform" the visit into codes. These codes ultimately reflect the severity of illness of the patient, and allow for appropriate and timely reimbursement.

"Rule of Thumb for Documentation" - If it isn't documented , it didn't happen.

Erik Hamilton, RN CDS

Physician Strategic Initiatives Meeting

Please join us on Friday, June 18th for a Physician Strategic Initiatives Meeting. The meeting will focus on pending healthcare reform and its effects on the medical community.

The meeting will be held at Pickwick Landing State Park Inn, 120 Playground Loop, Pickwick Dam, TN, on Friday, June 18th, from 9:00 a.m. – 11:30 a.m. A special MRHC Medical Staff Session will be held from 11:45 a.m. – 1:00 p.m.

If you plan on attending, please RSVP: 662.293.7680 or joanievaughan@mrhc.org.

Guest speakers will include: Peggy Tighe, J.D., who will be discussing *Healthcare Reform: Politics, Payment Policy & Process Going Forward* and Robert Marder, M.D. who will be discussing *Effects of Healthcare Reform: Hospital & Physician Quality Measurement & Competency Evaluation.*