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Letter from CEO, Rick Napper

The holidays are right around the corner and winter is starting to show it's head, at least temperature wise. The elections are over yet the work, challenges and issues remain. I anticipate the physician pay issue to be extended for a short period and booted to the next Congress. As budget issues continue, healthcare dollars are a target for many on Capitol Hill.

I have been focused on learning more about ACOs and bundled payment in an attempt to keep the medical staff informed about possible strategies.

We continue to advance in preparing the medical staff for the challenges of value-based purchasing, CPOE and Healthcare Reform. I am confident that the MEC has done a great job laying the foundation to launch the Medical Staff ahead of their peers across the nation as the challenges and changes begin.

I would be remiss if I did not thank Dr. Frazier for his outstanding performance during his term as Chief of Staff. His leadership and devotion to the medical staff lead MRHC to developing a strategy for dealing with the com-

plex issues that physicians face in today's environment.

On behalf of the Board and Administration I want to wish all of you a Happy Thanksgiving, please be safe and enjoy the time with family and friends. As always, I appreciate the hard work that you do.

Respectfully,

Rick Napper, CEO



Vice-President of Physician Operations, Don Lloyd

Surveys have shown that there is a movement in eight different areas that is shaping the medical practice industry.

8 is more than enough: Eight trends that will shape the future of medical practices

As we start the New Year, it is a time of reflection. What is the current state of your medical practice? What will happen under Healthcare Reform? Surveys have shown that there is a movement in eight different areas that is shaping the medical practice industry.

1. Integrated Delivery Systems

–The onset of physician employment arrangements, PHO's (Physician Hospital Organizations), IPA's (Independent Physician Associations) and now ACO's (Accountable Care Organizations) are being developed across the United States.

2. Health Information Technology

–With the American Recovery and Reinvestment Act

Incentives, the widespread adoption of Electronic Health Records is on the horizon.

3. Mid-level Recruitment – Nurse practitioners and physician assistants are being heavily recruited by medical practices.

4. Patient Payments – Patients are now more responsible for their healthcare costs and, this is changing the medical practice collection process.

5. AR (Accounts Receivable) – AR days are increasing, and it is becoming more difficult to collect reimbursements.

6. Payor Mix – The payor mix is shifting to more of a Medicare reimbursement especially in communities that lack PHO's and Integrated Delivery Systems.

7. Physician Recruitment –The demand to recruit more physicians continues to grow, but

the supply does not.

8. Physician Compensation – Physicians are now required to work much harder than ever to maintain their compensation levels.

To combat some of the issues listed above, our Tri-State HealthCare Group PHO and its 84 physician members and 46 medical practices have been able to maintain positive commercial reimbursement structures in comparison to other markets in our region. Magnolia Regional Health Center has developed a comprehensive physician employment model and a management service organization (MSO) to further enhance our physician integrated delivery system.

If you have questions or are in need of any assistance relating to the issues listed above, please do not hesitate to contact the PHO office at 662-287-6913.



Effective Communication in the Physician-Patient Relationship: Part One

Numerous controlled studies have validated the importance of effective physician-patient communication. There is a positive correlation between good communication and improved health outcomes/increased patient satisfaction. Research also indicates effective communication results in professional satisfaction and enhances the community image of the medical practice. Additionally, appropriate communication mitigates risk, as patients who are well informed about options, expectations, and possible complications are less likely to file legal claims.

Patient perception of communication is reflected on the Press Ganey survey. Year to date, a mean score of 87.3 inpatients responded their physician kept them informed. Ambulatory Surgery patients surveyed indicated satisfaction with physician explanations prior to sur-

gery 95.4% of the time, and information regarding what was done 94% of the time. In the Emergency Department, patients returned mean scores of 80.8 and 79.4, respectively, to the questions, "doctor took time to listen," and "doctor informative regarding treatment."

As time spent at the bedside becomes more and more constrained, the quality of communication is essential. The Academy of Orthopaedic Surgeons offers the following tips for skillful patient-focused communication.

- Show empathy and respect
- Listen attentively
- Elicit concerns and calm fears
- Answer questions honestly
- Inform and educate patients about treatment options and course of care
- Involve patients in decisions concerning their medical care

- Demonstrate sensitivity to patients' cultural and ethnic diversity

Next month we'll explore ways to cultivate and strengthen an effective personal communication style.



E-Safety First

Technology and knowledge are expanding at an ever accelerating rate. Every physician will be confronted with threats to their current position by economic forces, advancing technology, governmental regulations, changing patient expectations, and the need to remain knowledgeable in a world where the doubling time of knowledge is approaching 3 years. By the time a physician finishes medical training, much of what he/she learned is becoming outdated or incorrect. Because of this, patient care processes need to be redesigned in a way to reduce primary reliance on memory and vigilance – the two weakest links in the safe practice chain.

In a world that is becoming progressively more specialized, healthcare organizations are struggling to integrate patient care information. Creation of the electronic medical record is considered the key that will accomplish this integration on which high quality and safe patient care are dependent. But there are cultural elements that interfere with the safety and quality agenda.

Most physicians would define quality as “The way I take care of my patients.” This belief that “knowing” is the same thing as “doing” – the belief that good people who have received good medical training will make correct decisions - can be discredited as evidenced by the rate of

litigation in our healthcare system. How can we expect physicians to have the time and energy not only to take care of their patients, but to stay current on trends and technologies that are changing every day? This is where the utilization of electronic entry of standardized evidence based order sets can help. They act as a “checklist” of current recommended practices for physicians when ordering and provide conflict checks when prescribing medications while still allowing the physician to customize the orders to his particular patient.

The cultural norm of “No harm, no foul” represents another form of quality and safety interference. Recently, when being discharged from the hospital, I was given a prescription for a medication to which I was allergic. The nurse then had to call back the physician and have the prescription changed – “No harm, no foul”. This scenario is a common one. But what if I had taken the prescription as ordered and experienced an anaphylactic reaction at home after discharge? Therein lays the “foul”. The use of computerized physician order entry would have alerted the provider to the fact that I was allergic to the medication when it was ordered. At that point, the physician could have changed the prescription and avoided the callback as well as the “near miss”.

The Physician Care Manager project will not result in a perfect system of patient safety, and some physicians may not agree with it despite the probability of creating improved aggregated outcomes. Physicians and healthcare organizations should avoid allowing “Perfect” to become the enemy of “Better” and position themselves for sustainability.

When hockey player, Wayne Gretzky, was asked how he was able to score more goals than any other players, he was said to have replied, “I skate to where the puck is going to be.” He didn’t choose to skate where the puck was and certainly not to where the puck had been. As this analogy shows, physicians and healthcare organizations must seek to position themselves where they believe “the puck is going to be”. Failure to do so places them at a significant disadvantage.

Physicians should make the choice in issues of patient safety, such as the adoption of CPOE, to make participation non-negotiable. What would be the outcome be if Jeff Taylor, CFO only billed patients 80% of the time? By analogy, how can the medical community accept applying appropriate patient safety care standards, such as CPOE, by only a small percentage of the medical staff?

“It’s tough to make predictions, especially about the future.” –Yogi Berra



Documenting split-shared visits in the hospital setting

Medicare reimburses services provided by an NPP (nurse practitioner or physician assistant) alone at 85% of the rate it reimburses physicians. However, CMS reimburses visits shared between the physician and the NPP at 100% of the allowed amount to the physician. Remember that services must be within the scope of practice for the NPP.

To obtain the full reimbursement allowed, the physician must document his or her participation in the care of the patient along with the NPP's documentation of his or her portion of the care. If the documentation does not support the physician's presence and the portion of work the physician performed, the NPP should report the care alone.

Shared visit guidelines

Of course, both the physicians and the NPPs must follow CPT and CMS documentation guidelines. Guidelines reference two main types of shared visits; the differences between them may confuse coders. In the hospital inpatient setting, the shared visit encounters are referred to as split-shared visits. In the office setting the shared visits are referenced as incident-to visits.

Rules for reporting inpatient split-shared

When reporting an inpatient split-shared visit, remember these rules:

- The split-shared visit rules state that both the NPP and the phy-

sician must have a face-to-face encounter with the patient on the day the facility or practice reports the service.

- Both the physician and the NPP should document their participation of the visit in the medical record.
- The physician practice employs the NPP. Do not report a shared visit when a hospital facility or other entity employs the NPP.
- The physician cannot simply state "reviewed and agree" in the record without seeing the patient personally.
- CMS permits hospitals to report new and established patient encounters in the hospital setting as a split-shared visit.

In addition, the physician must perform and document at least some of the three key components of E/M services (i.e., the history, the exam, and the medical decision-making). Review the details of E/M services in your 2010 CPT® Manual.

No shared visits with consultation codes

The official CPT guidelines do not allow shared visits when reporting consultation codes 99241–99255. This rule has no bearing on whether a facility or practice may report consults in the office or the hospital. Medicare and many private payers do not permit shared visits with consultations.

The deletion of the CPT consultation codes benefits physicians who are appropriately documenting split-shared visits that take place in the hospital setting. The physician and the NPP may now share services previously reported as inpatient consultations. This reporting is advantageous financially, as it allows for more effective use of the NPP on a more regular basis.

You should now report the codes for inpatient consultations with the admission codes or the subsequent care codes that allow the use of split-shared encounters.

Physicians working in a physician office did not benefit from the deletion of the consultation codes. The crosswalk guidelines state that either the physician or the NPP should report consultations in the office as new patient visits.

Lastly, when reporting a split-shared encounter in the hospital setting, you may combine the documentation of both the physician and the NPP to report the highest level of service provided. The physician and the NPP do not need to see the patient at the same time, but they do have to see the patient on the same day. The physician should state his or her agreement and link to the NPP's note.

Joy Joyce, RHIA
HIM Director



Corporate Compliance

CMS Issues Two Medicare Learning Network (MLN) Memorandums on RAC High Risk Vulnerabilities

CMS has stated that it will strive to educate providers regarding the problems it identifies during audits. CMS has issued two new Medicare Learning Network (MLN) Matters Memorandums that address many of the medical necessity issues and documentation requirements.

MLN Matters SE 1027 <http://www.cms.gov/MLN MattersArticles/downloads/SE1027.pdf> addresses medical necessity issues from the RAC Demonstration period and the current period. It highlights 17 high risk medical necessity issues in order of gross, pre-appeal dollar recovery. The DRG's (Diagnoses Related Grouping) listed for inpatient hospitals range from Cardiac Defibrillator Implant with a reported pre-appeal recovery of \$64,739,622 to Percutaneous Cardiac Procedures with a reported pre-appeal recovery of \$2,314,001. The majority of the denials for these 17 issues were because the documentation submitted did not support that the services provided required an inpatient level of care and could have been provided in a less intensive setting. CMS reminds providers in this article that the medical record must demonstrate that

the patient's signs and/or symptoms were severe enough to warrant the need for inpatient medical care. Factors that providers should consider when making the decision to admit may include:

- the severity of the signs and symptoms exhibited by the patient;
- the medical predictability of something adverse happening to the patient;
- the need for diagnostic studies; and
- the availability of diagnostic procedures at the time and at the location where the patient presents.

Documentation that is not legible has a direct effect on the RAC reviewer's ability to support that the services billed were medically necessary and were provided in an appropriate setting. CMS encourages providers to ensure that all entries are consistent with other parts of the medical record. If there is a contradiction, CMS recommends that the provider include documentation that explains the contradiction. Additionally, CMS recommends that providers always document any changes in the patient's condition or care and that any amendments to the medical record after the physician documentation is completed be done in compliance with accepted stan-

dards for amending the medical record.

MLN Matters SE 1028 <https://www.cms.gov/MLN MattersArticles/downloads/SE1028.pdf> addresses the principal diagnosis of the patient being specifically identified by the attending physician. This is the condition, after study, to be chiefly responsible for the inpatient status. All "secondary" diagnoses must be identified by the attending physician. The general rules for reporting "secondary" diagnoses are:

- Must be documented by the attending physician and;
- Clinically evaluated or
- Diagnostically tested or
- Therapeutically treated or
- Causes an increase in length of stay or nursing care.

Additionally, CMS recommends that all procedures performed during admission be listed in the discharge summary. Please click on the websites to read the Medicare memorandums in their entirety. I hope this information is beneficial to you and we appreciate your continued help in improving our documentation.

Renee Bullard, 7673

Compliance/Risk Management



Clinical Documentation Improvement

This month's focus is on the "capture" or reporting of CC/MCC in the patient record. You will recognize these as the secondary diagnoses that are assigned or coded to the patient after discharge. A "CC" is defined as "complications and comorbidities". Comorbidities are conditions that coexist at the time of admission which affect the treatment received and/or length of stay. Complications are conditions that arise after admission that affect the treatment received and/or length of stay. These are also subdivided into the category of "MCC", which is a "major complication / comorbidities".

The effect of the CC/MCC on the patient's record can be evidenced by the diagnosis code assigned during the coding process, which will also help reflect the accurate severity of the case. This subsequently is reported in the physician's profile as to the type of patients that are being admitted for care.

Therefore, if you "think with ink" and document with specificity the problems that are addressed during the patient visit, both physician and facility will benefit.

General Tips to Remember

1. Chronic Kidney Disease: don't forget to specify the stage of disease if known (stage1-stage5)
2. Hypertension: specify (malignant or benign)
3. Lesions, Masses, and Lacerations: describe size (measurement) of the lesion or mass and/or the laceration being repaired
4. CHF: specify (acute or chronic or acute on chronic) plus systolic or diastolic

Documentation should be specific, clearly written, and repeated throughout the medical record. This 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, which reflects on the time and resources utilized in the care of the patient.

"Rule of Thumb for Documentation"

- If it isn't documented, it can't be coded, it didn't happen.