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Magnolia MedLink

Linking Physicians and MRHC

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Letter from CEO, Rick Napper

The heat of summer has passed and we are looking forward to the leaves falling and cool evenings, however the debate over healthcare rages forward as the elections are approaching. It is hard to update on healthcare reform because it is so complicated that we have launched into a holding pattern. I strongly believe that we will hear very little before the November elections and then, pending those results, we will begin to hear more about the overall impact. The fall however also brings with it the implementation of physician order entry, which will be a huge undertaking. We will be sending a number of people to Boston for training to assist the Medical staff as we begin this process. I feel confident that as we get the bugs worked out, physicians will see a significant improvement in the transfer of information at MRHC.

Also on the horizon will be another construction project that will involve moving the imaging facilities and ER into a facility to be constructed under the new tower. The fall will be a time of planning and submitting for state approvals while here at MRHC we will be reviewing drawings and space requirements. Before any new construction starts however, we will have the Grand Opening of the new MICU area. Having toured this facility I believe it is a facility that will make everyone at Magnolia proud. Our patients and visitors will see an immediate difference in the environment and comfort level of the new facility.

As always I want to thank you for the service you provide to MRHC and the community. I believe that eventually our country's leaders will come to the reality of the important role physicians play in our country. Hang in there and try to focus on why we all chose Healthcare in the first place.

Respectfully,

Ricky D. Napper

Rick Napper, CEO

Vice-President, Medical Affairs
Gene Combest, MD

Physicians, please note that the Order Set development team has placed a group of care track order sets in your mailbox for your review prior to the September 7th medical staff meeting. These orders have been reviewed and corrected, in some cases rejected, by some members of the active medical staff prior to submission to the entire medical staff. We seek your approval for these order sets to be placed in Forms Fast for general usage. These new order will be available for your use during the transition from written orders to computerized physician order entry (CPOE). These order sets are also being posted on the Physician Intranet site under the tab "Order Set Development". We have also included a copy of the CPOE Development and Maintenance policy on the website for you to review and comment on.

Vice-President of Physician Operations, Don Lloyd

The Center for Medicare & Medicaid Services (CMS) reminds all physicians to allow sufficient time for the Medicare crossover process to work.

Medicare Physician Professional Part B Updates for August 2010

Maximum period for submission of Medicare claims reduced to no more than 12 months

As a result of the Affordable Care Act (ACA), claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare.

Top five EDI reasons for Mississippi Physician claim rejections for August 2010

1. Procedure code requires referring physician NPI – 5,792 denials
2. Diagnosis code invalid for date service – 2,399 denials
3. Instream rejections Problem involving HIPAA required loops, segments, or values). – 2,158 denials
4. Physician NPI not found on crosswalk file – 1,165 denials
5. Paid and adjustment amounts do not equal claim charge – 1,102 denials

Surgery: Trigger Point Injections

As a reminder, the utilization guidelines section of the Local Coverage Determination (LCD) for surgery states that more than four trigger point injections in a year's time will not be covered by Mississippi Medicare. Physicians are encouraged to review this LCD to ensure compliance. LCD's for Mississippi can be viewed at www.cms.gov.

Medicare Payment Crossover Process

The Center for Medicare & Medicaid Services (CMS) reminds all physicians to allow sufficient time for the Medicare crossover process to work, approximately 15 working days after Medicare's reimbursement is made is sufficient.

If you have any questions regarding these updates, please contact the TSPO office at 662.287-6913.

Coding & E/M (Evaluation/Management) Documentation Guidelines

MRHC Internal Medicine Residents Get Ahead of the Game with Coding & E/M (Evaluation/ Management) Documentation Guidelines Presentation

In August, Terri Durham, CPC, Billing Supervisor with Magnolia Practice Solutions and Amy Vance, Claims Manager with Tri State Healthcare provided an educational presentation to the MRHC IM Residents on E/M documentation guidelines and coding. While all medical residency programs are focused on providing quality care, many programs often fail to include this important information to their participants. Therefore, when these physicians complete residency and begin to practice medicine, they do not associate their documentation with E/M coding. Terri Durham, CPC, Billing Supervisor with Magnolia Practice Solutions stated, "I am excited to see this education being provided at the residency level." Durham added, " In turn, I hope this will help our residents become conscious, productive practicing physicians."

The presentation covered the reasons why documentation is important: it facilitates evaluation, planning immediate treatment and a source to monitor a patient's healthcare over time; communication and continuity of care with other healthcare professionals; accurate and timely claims; appropriate utilization review and quality of care evaluations; and collection of useful data.

In addition, the presenters reviewed the seven components for defining E/M levels of service: history, examination, medical decision making, counseling, coordination of care, nature of presenting problem and time. Amy Vance, Claims Manager with Tri State Healthcare, stated, "Knowing the importance of documentation and choosing the correct level of service helps protect both the patient and the physician while improving coordination of care."

CLINICAL INFORMATION PORTAL (CIP)

When rounding on their patients, physicians consistently need to perform the same functions – view their list of patients and review the clinical data that has occurred since the physician last saw the patient. With the availability of physician rounding on a hand held device, the Meditech Clinical Information Portal or CIP, these select functions can be performed on a personal smart phone device (iPhone) or any device that has internet access.

The CIP functionality will be rolled out to physicians during the September MRHC Medical Staff meeting and will include a hands-on demonstration. Both before and after the medical staff meeting, physicians will be able to sign up for access and schedule a personal training session at their convenience.

With CIP access, the physician will be able to pull up a list of patients that mimics his rounding list in the Provider Workload Manager (PWM) Inpatient Rounding list. It will also pull in any physician patient list that he has set on his desktop computer to provide cover for. The physician will also have the ability to search for patients by name or by location.

With a touch of the screen, the physician can access specific patient clinical data as he is presented with results gathered on his patient in the last 24 hours. He may then choose selected clinical views in order to review pertinent patient data he chooses: Daily Summary, Vital Signs, Intake and Output, Allergies and Medications, Laboratory results, and Documents such as reports and notes.

When accessing a specific patient, the physician is immediately presented with the Daily Summary screens. This provides a 24 hour snapshot of all clinical data gathered on the patient in the last 24 hours. The physician may then use the touch screen to select specific results to view or choose another view from a drop down list. Daily Summary information is presented in an easy to read format with fishbone diagram and color coding to identify all abnormal lab results in yellow and all critical lab results in red.

Introduction of the Clinical Information Portal (CIP) as a part of the Physician Care Manager (PCM) implementation is an initiative to develop and improve products used directly by physicians at the point of care. The ability to view patient information on a smart phone (iPhone, etc.) is only part of a combination of mobile and fixed devices that will be available to clinicians to suit the needs of different users, settings, and preferences during our migration to a comprehensive electronic medical record.

If you haven't experienced CIP yet, contact the IT HelpDesk @ Ext. 1123 for access and a personalized demonstration!

Medical Trivia

In 1964 an event at the University of Mississippi Medical Center really had the world's press in a frenzy. Dr. James D. Hardy, professor of surgery and chairman of the department at the University of Mississippi Medical Center, and his team transplanted the heart of a chimpanzee - man's closest genetic relation - into the chest of a dying man. The world's first heart transplanted into man beat 90 minutes before it stopped.

Credit was given amongst the medical community to the Mississippi team for the 1964 operation saying it proved that "the feasibility of cardiac transplantation was now irrefutable."

This first cardiac transplantation operation performed in Mississippi - met with such dubious acceptance in the beginning - set the stage for all future heart transplantation. It demonstrated that surgical techniques perfected in nine years of work on animals would work in humans. The procedure proved that a transplanted heart would beat and support a blood pressure in a human host.

CDI Corner

This month I want to focus on two different documentation subjects: Hypertension and Palliative Care. I realize there is a vast difference between the two, however they both can greatly affect the SOI (severity of illness) and ROM(risk of mortality) indices. These are numbers that CMS and public reporting agencies use to describe our patient population.

Regarding hypertension, if a patient presents with "hypertensive urgency" or "severe hypertension", this is coded as simply essential hypertension. If the same patient were described as having "malignant or accelerated hypertension" this would code out to a higher severity, and, therefore, accurately reflect the complexity of the case.

On the subject of palliative care (comfort measures), unfortunate as it is to be put in that situation where you are addressing the end of life, there are some helpful tips to remember at that time. The order for "comfort measures", "hospice care", "terminal care", or "end of life care" all will generate, at the time of coding, a particular code which will identify these patients as receiving such care. There is no adjustment to the assigned DRG code, but it will reflect in MRHC's RAM (risk adjusted mortality) index. Remember, palliative care is focused on management of pain and symptoms and is an alternative to aggressive treatment for patients in the terminal phase of illness. The care provided is dependent upon the illness. A "DNR" order is insufficient for this code; the additional documentation of "comfort measures" must be present.

General Tips to Remember

1. CHF: specify (acute or chronic) plus systolic or diastolic; if needed, document unknown or NOS (not otherwise specified)
2. Respiratory Insufficiency or Failure: specify (acute or chronic), secondary to(specify condition)
3. Hypertension: specify (malignant or benign)
4. Wounds: specify type (ulcer, diabetic, etc.) also (complicated, infected, non-healing)
5. Lesions, Masses, and Lacerations: describe size (measurement) of the lesion or mass and/or the laceration being repaired

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, 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.

Centers for Medicare and Medicaid Services

CMS Issues FY 2011 Inpatient PPS Final Rule

The Centers for Medicare and Medicaid Services (CMS) issued the hospital inpatient PPS (IPPS) final rule for fiscal year (FY) 2011. It was placed on display in the Federal Register on July 30 and is expected to be published in the Federal Register on August 16. The final rule indicates that CMS will apply a "documentation and coding" adjustment of -2.9 percent, which represents one-half of the amount of FY 2008 and 2009 excess spending due to changes in hospital coding practices following adoption of MS-DRGs. CMS is also finalizing an adjustment of -2.5 percent for FY 2011 to the long-term care hospital standard federal rate for the effects of documentation and coding practices for FY 2008 and 2009 under the MS-LTC DRGs.

The final rule adds 10 measures to the Reporting Hospital Quality Data for Annual Payment Update data set for the FY 2012 annual payment update. Specifically, CMS is adding the following eight categories of conditions included on the hospital-acquired condition list:

- foreign object retained after surgery
- air embolism
- blood incompatibility
- pressure ulcer stages III and IV
- falls and trauma (including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock)
- vascular catheter-associated infection
- catheter-associated urinary tract infection
- manifestations of poor glycemic control

The other two measures are additional Patient Safety Indicators developed by the Agency for Healthcare Research and Quality – post-operative respiratory failure and post-operative pulmonary embolism or deep vein thrombosis. One current measure is being retired – Mortality for selected surgical procedures (composite). Two additional quality measures have been adopted for reporting in FY 2011 that will be used to determine the FY 2013 annual payment update.

Joy Joyce, RHIA
HIM Director

WELCOME

DR. MICHAEL PEERY

Magnolia Regional Health Center welcomes Michael L. Peery, DDS, MD, FACS, and his staff to our growing team. Dr. Peery, who became an MRHC employed physician in August 2010, has been practicing at MRHC since 2000. He will continue to practice at Corinth Ear Nose & Throat clinic.

Dr. Peery received his medical degree from the St. Louis School of Medicine and completed his residency at the University of Tennessee. He is a member of numerous professional organizations including the American Medical Association, American Academy of Otolaryngology and Head and Neck Surgery, American Rhinologic Society. Dr. Peery is a fellow of the American College of Surgeons and board certified by the American Board of Otolaryngology and Head and Neck Surgery.

*Corinth ENT will continue to provide complete allergy and audiology services. Tara Nails, Au.D., CCC-A, will continue to serve as the clinic's audiologist.

MAGNOLIA
CORINTH EAR, NOSE & THROAT

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Friday, 8:00 a.m. – 3:00 p.m.
Phone: **662.293.1565**
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For a complete listing of MRHC physicians, visit **www.MRHC.org**.

Risk Management

SEPTICEMIA V. SEPSIS

Septicemia tops risk areas with conflicting definitions and documentation problems. Septicemia is one of the 11 targets of CMS's Program to Evaluate Payment Patterns Electronic Report (PEPPER) which is a hospital-by-hospital comparative report on hospital billing. Hospitals face errors in this area for many reasons. For one thing, nationwide, there seems to be a lack of physician consensus about the meaning of septicemia, sepsis and other related diagnoses.

The definitions according to the ICD-9-CM Official Guidelines for Coding and Reporting, used by our coders, are as follows:

1. **Systemic Inflammatory Response Syndrome (SIRS)** generally refers to the body's systemic response to infection, trauma/burns or other insult, with symptoms including fever, tachycardia, tachypnea and leukocytosis. To diagnose SIRS, a patient must have 2 of these 4 symptoms: Fever of more than 38 degrees Celsius or less than 36 degrees Celsius, heart rate greater than 90 beats per minute, respiration of more than 20 beats per minute, and a white blood cell count of greater than 12,000 cells per microliter or fewer than 4000 cells per microliter.
2. **Sepsis** refers to SIRS caused by infection.
3. **Severe sepsis** refers to sepsis with associated acute organ dysfunction.
4. **Septicemia** is defined as a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms.
5. **Septic shock**, a type of severe sepsis, refers to circulatory failure and represents a type of acute organ dysfunction.

SIRS in particular is a thorn in the side of hospitals. It is very restrictive; patients can have multiple SIRS symptoms and two or more of the criteria above but if the physician doesn't have a suspected cause (for example, pancreatitis or trauma from a car accident), there cannot be a diagnosis of SIRS. You have to have a cause. The same applies to sepsis because an infection has to be detected to diagnose it.

There are other problems regarding sepsis that hurt hospital coding and billing. One involves "empiric sepsis." When physicians diagnose patients empirically, which means it is based on their experience and clinical knowledge even though there is no lab culture to prove it or the lab culture is negative, that's good enough for coders. Some doctors would argue with this and say you could not have empiric sepsis without a positive culture, however, the point of the diagnosis is to explain why the patient is getting sepsis treatment (e.g. antibiotics) without a positive culture. If the physician doesn't document empiric sepsis despite treating the patient for it, coders are stuck coding only what's in the chart (e.g. fever). That is bad for the hospital and the physician in terms of reimbursement and skewed mortality and severity of illness ratings and physician profiles.

Please let me know if you would like additional information regarding these diagnoses and the documentation requirements. We appreciate your help as we strive to improve our documentation.

Renee Bullard, 293-7673
Compliance/Risk Management