

Gaining Physician Buy In

From the
Perspectives of:
Large, Small,
Rural and
Academic
Communities

Presented by Vicki Dwyer, Nancy Kennedy, Robert Ossoff, and James Taylor



Vail Valley Medical Center

Facts & Statistics

Founded: 1965 - Not-for-profit 501(c)(3) organization

Accreditations:

- Level III Trauma Center, designated by the State of Colorado
- JCAHO certified (3 year)

Facilities: 58 bed, Rural Community Hospital

Employees:

- Regular: approximately 621
- Seasonal: approximately 101

Medical Staff:

- 263 full-time and affiliated physicians



Key Services

Hospital Services:

- Beaver Creek Emergency, Avon Urgent, & Gypsum Urgent/Emergent Care Centers
- Shaw Regional Cancer Center / Sonnenalp Breast Imaging
- Outpatient Surgery Center
- Women & Children's Center
- Howard Head Physical Therapy / Orthopedic Sports Medicine

Physician Offices:

- Aesthetic & Reconstructive Surgery
- Avanti Cardiology
- Eagle Care Clinic
- Mountain Surgical Associates
- Northstar Urology

Galichia Medical Group, P.A.

- Ownership
- Physicians & Specialties
- Non-Physician Providers
- Offices
- Outreach
- Diagnostic Testing



KAISER PERMANENTE®

- Program wide – 8.6 million members
 - 8 regions
 - 15,000 Physicians
 - 164,000 Support staff
 - \$43 billion operating revenue
 - 454 Office buildings
- Prepaid Health Plan...

“We were an HMO, now it is one of the plans we offer.”

- 80% of our growth comes from products that did not exist 5 years ago.

Kaiser Permanente Colorado

- 900 physicians in 19 clinics
 - Closed Panel HMO + FFS structure
 - 19 office buildings (span of 150 miles)
 - Contracted Hospitals (CA owns theirs)
- 520,000 patients in Denver metro area
- EMR for 16 years [EpicSystems]
- \$2.5 billion operating revenue
 - 5,900 Health Plan employees
 - Union employees
- 1 of 8 Kaiser Permanente regions

Vanderbilt University Medical Center

Facts and Figures

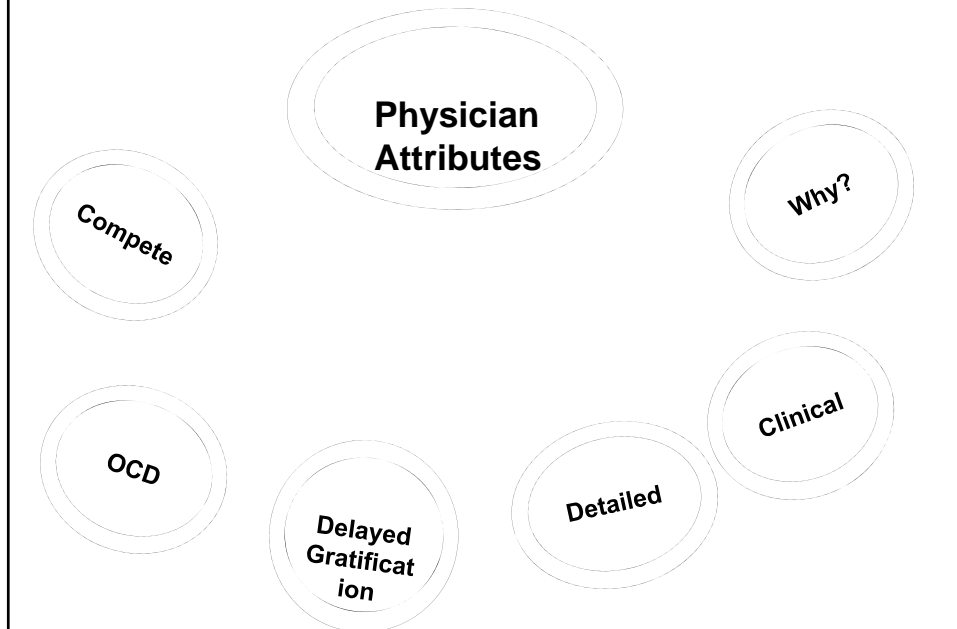
- 2245 total faculty
 - 1416 MD or MD equivalent
 - 633 PhD or PhD equivalent
- 1530 billing physicians and mid-levels in clinical enterprise
 - 1300 physicians
 - 230 nurse practitioners
- Four hospitals in VUMC
- EMR for 16 years (VUMC Star Panel)
- \$2.68 billion operating revenue

Vanderbilt University Medical Center

Facts and Figures

- \$3.46 million sponsored research funding
- 630 residents
- 250 ACGME fellows
- 30 non-ACGME fellows
- 436 medical students
- 638 nurse practitioner students

What makes a physician tick...



Physician Attributes – Small Entities

A Non-Clinical Point of View

- Establishing Personal Credibility
- To Debate or Not to Debate – That Is The Question
- Patient Care vs. Paper work

Physician Attributes – Small Entities

Non-Physician Providers

- Physician Assistants
 - Dependent Providers
 - Education & Training
- Nurse Practitioners / Clinical Nurse Specialists
 - Independent Providers
 - Education & Training

Physician Attributes – Small Entities

- Small Fish, Big Pond
 - “It Can’t Happen to Me”
- Politics, Politics, Politics
- Marching to Different Drummers

Physician Attributes - Vanderbilt

Interacting With Physicians

- Know your audience
 - Know their focus
 - Know their compliance risk
 - Know their characteristics

Physician Attributes - Vanderbilt

Know Your Audience

- Main focus
 - Patient care
 - Patient safety
 - Quality of care
- Compliance risk
 - Poor documentation
 - Incorrect billing
 - Risk management issues
 - Incorrect reimbursement
 - Increased cost to correct mistakes

Physician Attributes - Vanderbilt

General Characteristics:

- **Usually competitive in nature**
 - Like to be the best or a leader in their field
 - Compete with their peers as well as themselves
 - Like challenges
 - Desire perfection
 - Want to be correct

Physician Attributes - Vanderbilt

General Characteristics:

- **Interested in processes that**
 - Improve quality of patient care
 - **Improve patient safety**
 - Improve patient satisfaction
 - **Improve efficiency and productivity**
 - Improve reimbursement and cut cost

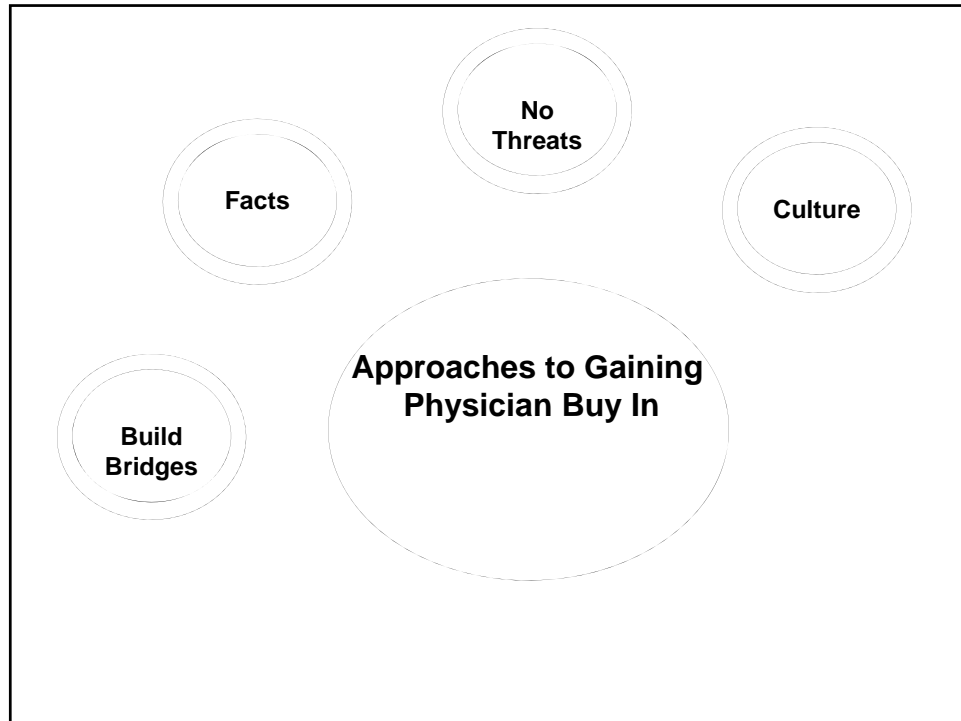
Physician Attributes - Vanderbilt

General Characteristics:

- **Education**
 - Highly educated in their field and/or specialty
 - **Usually interested in advancing their understanding of the healthcare industry**
 - Specifically interested in understanding outside factors that may impact them
- **Personality**
 - All walks of life but share common traits such as:
 - **Want to do the right thing**
 - Analytical thinkers
 - **Research, science and fact based oriented**
 - Entrepreneurial – like to think outside of the box and challenge Dogma

Physician Attributes - KPCO

- Docs don't scroll
 - **Be brief, be bright, be gone**
- Clicks are currency
- Medical Spam is still SPAM
 - **Minimize pop-ups and alerts**
- “Close enough” = Highest level specificity
 - **Preference List Maintenance**
- Slow Feedback is No Feedback
- Data Assassins
- Make the right thing to do the easy thing



Approaches to Gaining Physician Buy-In Small Entities

- **Education & Training**
 - Personalized One-on-One Approach
 - Positive Feedback
 - Getting credit for what you do
 - Simplify

Approaches to Gaining Physician Buy-In

Small Entities

- **The Way to Physician Buy-In is through the Staff**
 - Clinical Staff as Your Ally
 - Creating Compliance Advocates
- **Acting as a Consultant**
 - One Page Bio and Available Services

Approaches to Gaining Physician Buy-In

Small Entities

- **Facts, Not Scare Tactics**
 - Government Investigations
 - Government Enforcement (Integrity Agreements)
 - Been There, Done That

the power of hearing it first hand

Approaches to Gaining Physician Buy-In

Academic Physician Groups

Pointers – Build Bridges

- Capitalize on their general characteristics
 - Competitive by nature
 - Provide data when discussing compliance concerns that compare them to their peers, locally, regionally, and nationally, if possible
 - Be mindful of their time
 - Just the facts!

Approaches to Gaining Physician Buy-In

Academic Physician Groups

Pointers – Build Bridges

- Appeal to their interests
 - Demonstrate how documentation can
 - Improve the quality of care and improve patient safety
 - Improve overall efficiency and productivity
 - Improve patient satisfaction
 - Improve reimbursement and cut cost

Approaches to Gaining Physician Buy-In Academic Physician Groups

Pointers – Build Bridges

- Capitalize on their general characteristics
 - Education
 - Provide examples relative to their specialty
 - Provide data from their specialty organization
 - Explain how this helps them to be in the top of their profession and how compliance impacts their specialty
 - Personality
 - Ask for their input on how to better improve compliance
 - Provide facts about what needs to be improved and why
 - Explain why this is the right thing to do

Approaches to Gaining Physician Buy-In Academic Physician Groups

Pointers-Build Bridges

- Conversation starters
 - Dr. X, the Compliance Office has identified an opportunity you can use to
 - Improve patient care, patient safety and patient satisfaction
 - Improve the quality of your care
 - Ensure your documentation can be utilized more efficiently by yourself and other practitioners
 - Ensure your documentation reflects the excellent care you provide to your patients

Approaches to Gaining Physician Buy-In

Academic Physician Groups

Pitfalls – Instant Bridge Burners

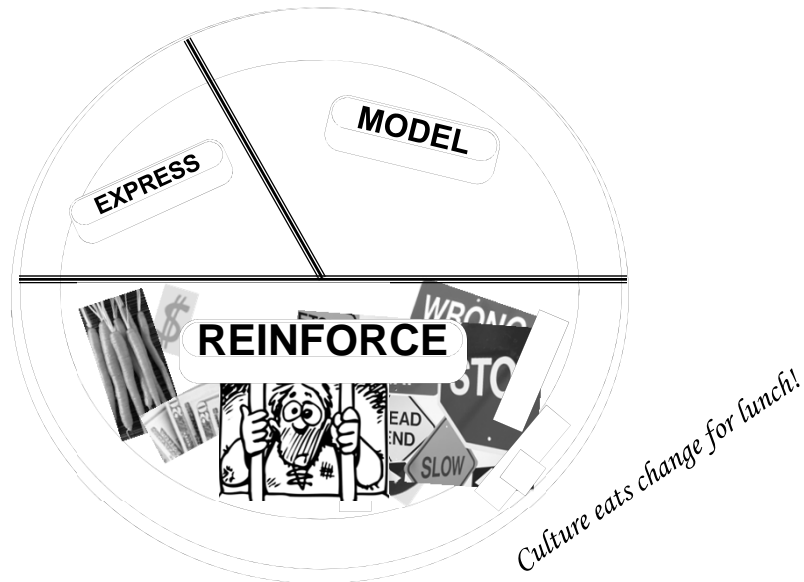
- Don't start off conversations with
 - Under the False Claims Act of 1863 you are.....
 - According to hospital policy HR – 40.02 you must.....
 - I've seen kindergarteners that had better documentation than yours and.....
 - If you expect to get paid you will do.....

Approaches to Gaining Physician Buy-In

Large Physician Groups

- Come alongside the culture and guide
- Don't hit head on
- More carrots than sticks
- Explain the why: if they understand why, the how is easy.
- Executive sponsorship is the secret sauce
- Reward quality before quantity

Kaiser Permanente Change Approach



Approaches to Gaining Physician Buy-In

Large Physician Groups

ENCULTURATION

- Monthly 1:1 Coding Review of 10 Cases
- “How do you code this visit” in every CME case
- Orthopedic Surgeon discussing 25 modifier
- Physician Director of Revenue Cycle/Coding
- Disease a Month
- Revenue Cycle “Mythbuster” one pager
- Departmental Relevant Training
- Chronic Diagnosis Monthly Reports

“This is not an initiative, it is the way we do business.”

Impacting Physician Culture

- 1
- 2
- 3
- 4

Impacting Physician Culture

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The New Paradigm

- CMS has started to realize the importance of quality care rather than just compliant billing for care provided
- CMS has begun to transform itself from a passive payer of services to an active purchaser of higher quality, affordable care
- Quality care means better outcomes and lower overall cost

The New Paradigm

- Quality is a viable marketing strategy
- Compliance with providing quality care is the law in New York under their Medicaid Program
- CMS has started denying costs associated with some hospital acquired illnesses as an incentive for provider to comply with the push towards reduction of medical errors or hospital acquired infections
- Those of us in Compliance expect this trend to continue

Board Involvement and Participation

- Daniel Levinson, Inspector General, reminds boards that quality of care is a compliance concern and there is a material linkage between Medicare/Medicaid billing to the quality of patient care
- Board Member's "lack of medical background" is not an excuse to defer to physicians' scrutiny of quality-of-care indicators.
- The IG also links the billing issue to broader board concerns about financial stewardship.
 - Corporate Responsibility and Health Care Quality, 2007
 - Trustee Engagement and Hospital Success, July/August 2009
 - AHLA Business Law and Governance Practice Group, August 2010

Ventilator Associated Pneumonia cases

- **National Data**
 - In 2003, VAP was the 2nd most common nosocomial infection making up 15% of all hospital acquired infections
 - VAP rate was 9% to 70% of patients on ventilators
 - ICU stays increased by several days
 - Overall hospital stay increased by 1 to 3 weeks
 - Mortality occurred 13% to 55%
 - Cost to the bottom line approximately \$40,000 to \$50,000 per stay
- **Goal: Improve quality to reduce VAP**

Quality of Care – Vanderbilt Specific Improvement Plan

- ICU Teams in 6 adult ICU's in October 2007 adopted standardized preventive measures for ventilator patients
 - Most preventive measures were already required to be compliant with The Joint Commission Standards
- Ten months after implementation, ICU VAP rate decreased by 41%
 - Meaning 86 fewer cases of VAP
 - Saving an estimated 13 lives
 - Reducing cost between \$1.9 million and \$3.5 million
- Compliance with clinical protocols, TJC requirements and continuous monitoring all played a factor in this success story
- Improvement to this process continues

- CMS understands the importance of paying for quality care
- There are numerous demonstration projects underway that are funded by CMS to study the impact of how quality care can decrease the cost to the Medicare and Medicaid Trust Funds
- These models are expected to increase the opportunity for pay for performance but also increase the chance of penalties (e.g. reduced reimbursement) for hospital acquired illnesses
- It is extremely important that your Compliance Office understand the link between quality and compliance

Compliance Program - Galichia

- **Established 1998**
- **Compliance Officer**
- **Compliance Department**
 - Audit
 - Risk Management
 - Provider Credentialing
- **What sets us apart**

Compliance Program – VVMC

- **Compliance Officer – One Woman Show**
 - All Things Compliance
 - Investigational Review Board
 - Ethics Resource Committee
- **What sets VVMC apart**

Linking Compliance & Quality

– **Communicating Quality Measures**

- PQRI
- Core Measures
- HEDIS
- CERT
- RAC
- OIG

Linking Compliance and Quality

– **Loading the Bases**

- Quality of Care
- Good Documentation
- Risk Management

Linking Compliance and Quality

– **Examples - Handout**

- Quantity without Quality
- Where's the Documentation
- Now That's Documentation!

- Physicians care about compliance but they care more about clinical quality.
- Frame issues around quality of care or quality of career
 - “It helps you partners take better care of...”
 - “This is a patient safety issue because ...”
 - “You’ll save time in the long run if..”
 - “It’s less clicks when ...”

1

- Yearly simulated CMS Audit
 - CAP's: EMR, Physician Education, IT fixes
- 100% review of all high risk diagnoses
 - Stroke/late effects; cancer/history of; etc.
- Reward Quality not Quantity
- Hospital MD CDI auditors

Impacting Physician Culture

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Physician Champions – Or the Lack Thereof

- The Black Knight
 - Not Learning the Rules
 - Putting Their Own Spin on the Rules
 - Talking the Talk but not Walking the Walk
 - Intimidation

Physician Champions – Or the Lack Thereof

- The Knights in Shining Armor
 - Clinical Staff
 - Point of Service Coders
 - Auditors
 - And YES – the Compliance Officer

2

Physician Liaison - KPCO

Peer to Peer Learning

Better translation of compliance to clinical
KPCO Structure

- Physician Director of Revenue Cycle/CMS
 - **Physician Audit Team**
 - Stroke/Deletes

2

Physician Liaison - KPCO

- Physician Director of Coding Education
 - **CDI Hospital physicians**
 - **Surgical Liaison (Peer to Peer)**
- Departmental Champions

Build Physician - Compliance Office Relationships

Politics do play a role

- You need buy-in from the top
 - CEO, CFO, COO
 - These individuals have a significant, vested interest in compliance. It is these individuals with whom you discuss increased efficiency, decreased risk of penalties, fines, and so forth.
 - If these individuals are on board with the compliance program, it should make it easier to get physician buy-in and involvement

Build Physician - Compliance Office Relationships

Develop your Physician Champions

- Where to start?
 - Respected physicians you know may be sympathetic to the goals and objectives of the Compliance Office
 - Grass roots approach
 - Which physicians are already involved in compliance-related areas
 - » Risk management
 - » Quality measures
 - » Patient safety
 - » CMO and COS
 - » Accreditation and Joint Commission
 - » Physicians with prior experience of an OIG investigation or a CIA
 - » Other

Build Physician - Compliance Office Relationships

What will the Physician Champions do once the relationship is developed?

- They are eyes and ears among their physician colleagues
 - Report on areas of concern from a physician's point of view
- They serve as advocates for the Compliance Office
 - They may be the ones to carry the “compliance torch” among their peers
- Most importantly, they are your liaison between the medical staff and the Compliance Office and can be instrumental in advocating for change within an organization
 - Assist with breaking down the us vs. them mentality
 - Encourage reporting of violations and suspected violations
 - Influence physician participation in educational programs

Build Physician - Compliance Office Relationships

Theory to implementation - Vanderbilt approach

- Implemented a program involving physicians to advocate for compliance:
 - Designated Coding Experts (DCE) and Designated **Coding Advocates (DCA)**
 - Compliance liaisons for faculty physicians/Compliance Office
 - Meet monthly to discuss changes related to coding, compliance, proposed regulatory changes and changes to the healthcare industry in general
 - Representatives from all specialties are involved
 - Supported by leadership (CEO, COO, CFO)

How Can the Compliance Office Help the Physician Champions?

Physician champions will need assistance from the Compliance Office

- These Physician Champions will receive questions from their peers so it is critical that they understand some basic, fundamental compliance issues
- High altitude – be their advisor and advocate

How Can the Compliance Office Help the Physician Champions?

Physician champions will need assistance from the Compliance Office

- Understand the Compliance Program Plan
 - Why we have one in place and how it impacts the daily lives of their physician colleagues
 - Conflict of interest
 - Fraud and abuse laws (Anti-kickback, False Claims, and Stark)

How Can the Compliance Office Help the Physician Champions?

Physician Champions will need assistance from the Compliance Office

- Major changes within CMS
- The new alphabet soup
 - Understanding the acronyms, alone, may be overwhelming!!!

How Can the Compliance Office Help the Physician Champions?

High altitude – be their advisor and advocate

- Assist with annual compliance training
 - Helps with both clinical and non-clinical staff to see that the Compliance Office is utilizing physicians to assist and provide guidance with training

How Can the Compliance Office Help the Physician Champions?

Sea level – be their consultant

- Individual physician audits
 - **Utilize your Physician Champions to help explain audit findings**
 - Less intimidating for the audited physician
 - Helps transform the audit into a collaborative approach to address the findings, mitigate the risks, and improve patient care
- Specialty compliance training
 - **Training is provided by someone in the specialty practice**
 - Peer to peer training
 - **Provide real-world insightful examples and commentary on why compliance is necessary within the specialty**

How Can the Compliance Office Help the Physician Champions?

Sea level – be their consultant

- Billing, coding, documentation, and operational issues
 - The Physician Champions encounter the same issues all physician's encounter so they can provide assistance with resolving these issues as they arise
- Leverage their “referral” behavior and training
 - The Physician Champions can “refer” their peers to the Compliance Office to assist with questions or concerns

How Can the Compliance Office Help the Physician Champions?

DCE/DCA – how the Physician Champions help the Compliance Office

- There are many benefits for the Compliance Office to utilize this approach
 - Impact to the organization's culture:
 - **Physicians participate with the Compliance Program so they too want to see it succeed**
 - **It's our program, not just the Compliance Office's program**
 - **Compliance is seen as part of the job – part of the daily routine**
 - **Are we perfect? No, but non-compliance is seen as imperfection and culturally we strive for perfection**

Utilize and Leverage Relationships with Your Physician Champions

DCE/DCA – How the Physician Champions help the Compliance Office

- There are many benefits for the Compliance Office to utilize this approach
 - Education
 - Changes to CMS requirements that involve changes to physician documentation is far more easier to implement
 - Education, is easier because the Compliance Office has excellent access to various committees through the Physician Champions
 - Network
 - You are automatically "linked-in" with the Physician Champions' peers
 - Creates the perception that the Compliance Office is more approachable

Impacting Physician Culture

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Principles:

- Slow feedback is no feedback
- Doctors do what you inspect, not what you expect (Hawthorne Effect)
- Make the right thing to do the easy thing to do.

Structure

- Embedded Auditor/Educator
 - **Located in department**
 - **10 Charts per doc per month**
 - Diagnosis, E&M, Procedure
 - MA HCC Diagnoses
 - Practice Management/RVU/Bell Curves
 - **20 minute a month feedback session**
 - **Coding Spotlights in Department Meetings**
 - **“Coding Certified” = less meetings with coder**
- 40 physicians per coder
 - **80 physician department would have 2**
 - **Smaller departments are grouped to get to 40**

Education

- Education is critical to keep compliance staff up to date on the changing landscape
- Compliance staff need to be educated on implementation and management of an effective compliance program but also on various new laws that impact health care-related fraud enforcement
- Education programs are going to be even more critical to keep faculty and staff up to date on the rapidly evolving regulatory landscape
 - **Physician buy-in to the compliance program and compliance efforts is extremely important but commonly overlooked**

The Small Entity Process

- Initial Training
 - Creating New Habits vs. Changing Old Habits
 - One-on-One
- Annual Training
 - Small vs. Large Group
 - Show and Tell

The Small Entity Process

- Keeping Everyone On the Turnip Truck
 - Quick & Dirty – Point of Service Review
 - Down & Dirty – Scheduled Audits
 - Timely Feedback & Education
 - Celebrate the Small Victories

3

The Small Entity Process

Upcoding and Clustering and Cloning – OH MY!

- OIG Identified Risk Areas
- Bench Marking
- Confidential Disclosures

Impacting Physician Culture

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- Legislation is forcing you to adopt an EMR
 - **HITECH Act 2009**
 - Establishes financial incentives for implementing EMR
 - Also establishes financial penalties for not implementing an EMR
 - **Incentives are based on when you implement an EMR**
 - **Penalties begin 2015 with a 1% reduction in payments.**
 - Penalties increase each year by 1% until 2020 maxing out at 5% reduction in reimbursement
- Whether you accept the carrot or wait for the stick, you will implement an EMR eventually

- Challenges to expect once you implement an EMR
 - Copy and Paste (possible cloning)
 - Order Sets
 - Clarity of Orders for Tests

- EMR is an excellent tool for correcting and resolving issues such as:
 - **Legibility of documentation**
 - Immediate availability of documentation for providers in emergency situations
 - **Improving the overall documentation to reflect the quality care provided to the patient**
 - Documentation for large systems can be readily available in one central location

- Copy and Paste
 - **EMR is designed to improve efficiency with the delivery of health care by providing a tool to speed the process of documentation**
 - Copy and Paste is an excellent functionality of the EMR if used correctly
 - **Depending on your geographic region, payers may or may not have weighed in on this topic**

- Copy and Paste
 - **Cloning concern**
 - Ask your MAC for guidance!
 - Cahaba GBA FAQ Response:

“The medical necessity of services performed must be documented in the medical record and Cahaba would expect to see documentation that supports the medical necessity of the service and any changes and or differences in the documentation of the History of Present Illness, Review of Systems and Physical Exam.”

- Copy and Paste
 - **Develop safeguards should your organization allow this functionality**
 - Develop Policies regarding the appropriate use of this technology
 - **Develop Education on the appropriate use of this technology**
 - Develop Compliance Audits and tools to review the use of this technology
 - **Develop Disciplinary Action Plan for those that inappropriately utilize or abuse this technology**

Order Sets

- Standardized
- Templates should be evidenced-based
 - **Should be supported by published research**
 - Should support medical necessity for the service to be performed
 - **Should be crystal clear leaving no question as to what the order set means**
 - Involve clinical staff in the creation of all protocols
 - **Goal to have only one protocol or order set when possible for a given situation**
 - Avoid frequent customization by physicians
 - **Consider the involvement of who can**
initiate and manage a protocol or order set

Order Sets

- Example: Current CMS Audit of CBC vs. CBC w/Diff
 - **CMS focused audit has determined that numerous facilities can not produce an order to substantiate CBC w/Diff**
 - Order written or selected states CBC
 - **Service performed was CBC w/Diff**
 - CMS recovering payment because service performed was not ordered
 - **Overpayment per service is approximately \$1.40**
 - Letter received by Compliance Officers for the state of TN providers from MAC warning that failure to implement measures to correct this error may result in referral to ZPIC for fraudulent billing

Clarity of Orders for Tests

- Legibility is no longer an excuse that the wrong test was performed
- **Order must be documented**
- Orders for tests should be clear and concise
 - **The exact test to be ordered should be clearly indicated (e.g. ordered by the practicing physician or person authorized by the state to write an order) and be medically necessary for the treatment of the patient**
- Performing a test based on an unclear order can result in denial of payment

EMR - How to Drive Compliant Documentation

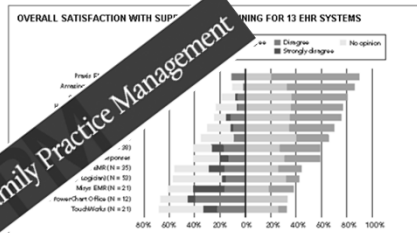
- **The Long & Rocky Road to EMR**
 - Creating a Checklist
 - What You Want
 - What You Want to Avoid
 - Getting Physician Buy-In One More Time

- **Templates**
 - Capturing ALL Required Elements
 - Starting Slow
- **Listen and Learn**

- **Templates**
 - Capturing ALL Required Elements
 - Starting Slow
- **Listen and Learn**

“Good implementations never end, only bad ones do...”

“Good implementations never end, only bad ones do...”



Close Visit Validation

Mandatory tasks to close note (require this as a minimum)

- **Orders signed**
- **E&M done**
- **Diagnosis Entry**
- **Progress Note Created**
- **Diagnosis/Order Association (medical necessity)**

If the doctor does not complete these five tasks, the encounter stays “open” and shows up in their Open Encounter folder in their in-basket.

I try to close the note and get this pop-up

Close Encounter

Required Items

- [No level of service for this encounter](#)
- [No diagnosis for this encounter](#)
- [No additional progress notes found.](#)

Close Encounter

Recommended Item

- [This encounter contains orders and/or medications that do not have an associated diagnosis. Please associate these orders before closing this encounter.](#)

Examples: items required before MD closes the note.

The [hyperlink](#) takes you directly back to the portion of the chart that requires the additional documentation.

Drop down lists

Significant Barrier to Accurate Coding

- Thoughtful Creation and Careful Maintenance
- Department Specific

General Guidelines:*

- “Do not use drop-down lists with fewer than three items, or more than about ten. To offer a choice of two options, use radio buttons or toggle buttons. To offer a choice of more than ten options, use a list.
- Do not initiate an action when the user selects an item from a drop-down list. (MD must review choice before taking action)
- Use sentence capitalization for drop-down list items, for example, *Switched movement*.”

*Available at: <http://library.gnome.org/devel/hig-book/stable/controls-options-menus.html.en>

Drop down lists

Foundational Principle Application: Docs Don't Scroll

Drop down list priorities

8-10 choices (with options to click to more)

Alphabetical order

Anatomical or physiological

Physician Input Required

Clinically Correct

Best Practice Based or Guide Best Practice

Periodic Review for Clinical Accuracy

*Available at: <http://library.gnome.org/devel/hig-book/stable/controls-options-menus.html.en>

Alerts: Any strength taken to an extreme becomes a weakness

ALERT FATIGUE

Very common in CPOE

- Too many interruptions leads to overriding
 - 2,900 MD's in MA, NJ, PA
 - 230,000 alerts ignored 90% of time
 - Another study: Safety alerts ignored 49-96%
 - Setting alert to "critical/high severity" decreases rate

Prostate Cancer Alert in KPCO:

- Initial Diagnosis accuracy 50% → 97%
- Now 84% → 96%

Diagnosis Accuracy Pop-Up

BestPractice Alert - Zzdrtest,Maria

▼ DISEASE MANAGEMENT REMINDER: To use this diagnosis, you must have documented in your note that the cancer is active or exists and/or the current treatment for the cancer.

ACTION: IF NOT ACTIVE, use History of Prostate Cancer - enter Hx Prostate in the Encounter Diagnosis field to select.

Accept

Cancel

Evaluation & Management Coding

Point of Care Reminders to Complete E&M

Hover Text States Rules of E&M Coding

Once each key component level is selected, the computer assigns the codes based on the level picked for History/Exam/MDM or Time

The only way the EMR can chose the code:

- All documentation is structured text
- Natural Language Processing “reads” the note
- Both pose significant overcoding challenges

The screenshot displays the 'Level of Service' software interface. The 'Service' dropdown is set to 'OFFICE/OUTPATIENT (1)'. The 'Preview' window on the right shows 'Exam, Expanded Problem Focused' and lists two options: '95 2-4 Body Area/Organ System' and '97 6-11 Elements (Specialty Dept)'. The 'History' section has buttons for 'Problem Focused', 'Expanded Problem Focused', 'Detailed', and 'Comprehensive'. The 'Exam' section has buttons for 'Problem Focused', 'Expanded Problem Focused', 'Detailed', and 'Comprehensive'. The 'MDM' section has buttons for 'Straightforward', 'Low Complexity', 'Moderate Complexity', and 'High Complexity'. The 'Currently selected levels' section shows 'History: None selected.', 'Exam: None selected.', and 'MDM: None selected.'. A text box at the bottom right explains that the preview window will display HELP text when the mouse is hovered over any 'Level of Service component button'. The text box also states: '95 and 97 rules are built in so different departments have the option to use one or the other'. The interface includes a 'Modifiers' section with four input fields, an 'LQS Code' field, and buttons for 'Analyzer', 'Accept', 'Restore', and 'Cancel'.

Level of Service

Service: OFFICE/OUTPATIENT (1)

Preview: Exam, Expanded Problem Focused

95 2-4 Body Area/Organ System

97 6-11 Elements (Specialty Dept)

BA: Head/Neck/Chest/Abd/Genital/Back/ Each Ext

OS: Constitutional/Eye/ENT/CV/Resp/GI/GU/MSK/Skin/Neuro/Psych/Heme-Lymph-Immuno

Currently selected levels

History: None selected.

Exam: None selected.

MDM: None selected.

Additional Help Text: The preview window above will display HELP text when you hover your mouse over any Level of Service component button. This text describes the required elements of history, physical or medical decision making which must be performed and documented to complete Evaluation and Management.

95 and 97 rules are built in so different departments have the option to use one or the other

Analyzer Accept Restore Cancel

4

Diagnosis Accuracy: POS Education

Cancer versus "History Of"

Acute Stroke

BestPractice Alert - Zzdrtest,Maria

▼ DISEASE MANAGEMENT REMINDER: To use this diagnosis, you must have documented in your note that the cancer is active or exists and/or the current treatment for the cancer.

ACTION: IF NOT ACTIVE, use History of Prostate Cancer - enter Hx Prostate in the Encounter Diagnosis field to select.

Accept

Cancel

One click for the doc, two codes for the coder!

Preference List Matches

Match: dm 2 retin|

Code	Name
500621	DM 2 W DIABETIC BACKGROUND RETINOPATHY
	ETIOLOGY manifestation

CLINICAL EMR: Administrative Code 500621

BILLING SUITE EMR: Administrative Code 500621

500621 deleted and 250.50 + 362.01 added

Claim Diagnoses: 250.50 + 362.01

Example: Watermark + Time/Date Stamp + Notification sent to Initial Author that record had additional documentation entered after note was closed

JAMES TAYLOR, MD Physician Status: Addended

Test addendum to medical record
Last edited by: JAMES TAYLOR, MD (8/12/2009 10:34 AM)

Follow-up
No follow-up instructions entered

Sign/Route Addendum
No recipients entered

Sign Addendum

Message that appears in initial author's In-Basket to alert of additional documentation

My In Basket	James M Taylor's In Basket >> Addendum Notification				
James M Taylor's In Basket	Status	Visit	Patient	Added By	DtAdded
Addendum Notification	New	03/24/2009	Zz, Zzjojtest	Rhoades, Linda S	03/24/2009
CC'd Charts (1)					
INCOMPLETE CHART					
Coding Assistance					

Copy and Paste: EMR's make it more difficult



Thank You!

Credentials

Vicki Dwyer, RN, MN, CHC, CPC
Compliance Officer
Vail Valley Medical Center, Vail, CO

Nancy Kennedy, RHIT, CPC
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Galichia Medical Group, Wichita, KS

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James Taylor, MD, CPC *[Family Medicine]*
Medical Director of Revenue Cycle & Benefits
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