

Medical Records Briefing

The Newsletter for Health Information Management

EHR beat

Convey EHR benefits to get physicians on board

One hospital highlights patient care, time effectiveness, and physician recruitment

When Sun Health, a nonprofit, community-owned network of healthcare services in Sun City, AZ, embarked on an EHR implementation, it knew that its physicians had to be on board.

"If physicians are not involved, your program may not be a success," said **Ramanjit Dhaliwal, MD**, of Sun Health during the annual American Health Information Association conference held October 7–10, 2007, in Philadelphia. Dhaliwal spoke about several physician-related barriers to EHR implementation, as well as strategies for overcoming them.

Convey patient care benefits

At Sun Health, getting physicians on board required significant training and education with respect to EHR

benefits. HIM professionals who worked at Sun Health hospitals wanted to emphasize that an EHR would enable physicians to maximize time with their patients, said **Barbara Knight, MA, RHIA, CPHQ**, director of medical records/quality management at Boswell Memorial Hospital.

Boswell Memorial, a 355-bed facility, is one of three hospitals in the Sun Health Network. The others are Del E. Webb Hospital and Boswell Rehabilitation Center, which have 307 and 115 beds respectively.

Because seven miles separate the three facilities, physicians spent significant time traveling between them to retrieve records before EHR implementation, Dhaliwal said.

The EHR allows physicians to dictate reports that other physicians can easily view in real time without the inconvenience of traveling to another location. This was particularly helpful for ER physicians, said Dhaliwal.

"In the ED [emergency department], it may take 15 minutes to get a chart," he said. "Now, the ED physician doesn't have the excuse not to get the information."

"When we're trying to recruit a new physician, the first question that he or she asks is whether we have an EHR. It could hurt your recruiting process."

—*Ramanjit Dhaliwal, MD*



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—*A Minute for the Medical Staff*, by James S. Kennedy, MD, CCS

Highlight other time-saving benefits

Sun Health officials also emphasized other benefits. Specifically, they said, HIM would be able to implement remote coding, which would help attract and retain qualified coders.

In addition, the EHR would provide:

- A cost-effective document management system for reviewing, editing, signing, and retrieving documents

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EHR benefits

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- Automated chart analysis, deficiency tracking, and electronic signatures
- Electronic access to Sun Health's longitudinal medical record for personnel at all three facilities
- Electronic document access not only for physicians, but also for HIM and other clinical departments
- An electronic repository of the permanent legal health record

If these benefits fail to attract physicians' attention, Dhaliwal recommended reminding them that an EHR will aid physician recruitment.

"When we're trying to recruit a new physician, the first question that he or she asks is whether we have

an EHR," Dhaliwal said. "It could hurt your recruiting process."

Provide detailed training

Despite the obvious benefits, persuading physicians to learn the new and often daunting EHR system can be the biggest obstacle to implementation, said Knight. Sun Health overcame this hurdle by providing a strong support network for its physicians.

"We did a lot of hand-holding," said Knight. This included individual training by phone and in the physician lounge and physician offices, she said. "Many [physicians] were very nervous. We started basic, such as how to provide an electronic signature."

It's important to make the physicians feel as though the EHR is not an imposition, said Dhaliwal. Provide detailed training and consider appointing a physician champion. Identify someone who will be an enthusiastic advocate for EHR implementation and encourage his or her colleagues to participate, he said.

"Who are the true physician leaders? It may only be five to 10 physicians at each hospital," Dhaliwal added.

Recognize other potential benefits

Consider the following additional potential benefits of an EHR:

- Reduced coder vacancy rate (Sun Health currently has a 0 vacancy rate and hires staff remotely)
- Reduction in full-time clerical employees (Sun Health experienced a 20% reduction in this area)
- Increased coder productivity (Sun Health experienced a 40% increase in productivity)
- Reduction in discharge-not-final-billed (DNFB) (Sun Health experienced a \$10 million reduction in DNFB)
- Remote access to scanned records
- Reduction in the suspension rate (Sun Health's suspension rate is currently in the single digits)
- Reduction in the HIM department hours of operation ■

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Joint Commission survey watch

Case study: One hospital monitors its H&Ps to set benchmarks, significantly reduce the delinquency rate

Many hospitals will admit that obtaining timely history and physicals (H&P) is no easy task. But not many hospitals can boast a mere 0.9% H&P delinquency rate. Brownwood (TX) Regional Medical Center, a 195-bed facility, is one exception.

Despite stringent CMS and Joint Commission (formerly JCAHO) guidelines that require providers to document an H&P within 24 hours of admission, Brownwood has been able to educate its physicians and accomplish this enviable goal.

"Physicians are very busy, so it's easy for them to miss dictating an H&P on occasion," says **Carla Williams**, statistical analyst for Brownwood. This was part of the problem in the beginning, she adds. In 2003, the H&P delinquency rate was 3.4%.

Medical record delinquencies are common

H&Ps were not the only untimely part of the medical record, says **Judy Martin, CPMSM**, physician services director for Brownwood. "The operative reports and the discharge summaries were also late," she says.

The hospital had to start somewhere, so it began working on timely completion of H&Ps in 2002. This is where Williams' role came in. Although she does perform various statistical analyst duties throughout the department, nearly half of her day is devoted to tracking delinquent reports. This involves checking electronic records, checking paper charts (if the physician still handwrites his or her report), and listening to the dictation system to ensure that the H&P is there but not yet transcribed.

Williams' process for notifying physicians of absent H&Ps includes placing bright green stickers on charts, faxing notification to the physician office, and placing a complimentary reminder call to the physician's office. If the H&P is still absent the next morning, she repeats the process.

Williams logs all the actions that she takes throughout the month and at the end of the month forwards the information to the HIM director, who then enters all of the data into a spreadsheet according to physician name and the type of report. The director submits the data to the medical executive committee each month and to individual physicians on a quarterly basis. In 2005, the medical staff amended its bylaws so that effective January 1, 2006, physicians became accountable for their delinquencies through the reappointment process.

It's all in the details

Tracking the entire process is as important as monitoring the delinquencies. Williams keeps a detailed account of the information she seeks and how often she seeks it. She must also convey the importance of these details to the physician. For example, a physician needs to understand that when he or she admits a patient on a Friday or Saturday, the H&P must be dictated right away. If he or she doesn't dictate it until Monday, the H&P will be delinquent.

"We have done so much education with our physicians that they understand the process. There are very few physicians placed on the delinquency list anymore," says **Wanda Davis**, HIM director for Brownwood.

Because of the detail-oriented nature of the job, the individual who serves in this role must be organized and not timid. "Communication is big. It's not hard after you get going and [the physicians] know what you're doing. You just have to be persistent," says Williams.

The medical staff established a 10% benchmark that all physicians must meet, meaning that each physician must keep his or her delinquencies below 10%.

"The Joint Commission and Medicare tell you that you have to be 100% compliant, but you have to start

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Case study

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somewhere. It's really hospital-specific as to where you want to start your process," says Davis. Brownwood's medical staff chose the 10% mark after monitoring its physicians over a period of time and determining that the majority of the medical staff fell well below 10%.

According to the bylaws, when the physician doesn't meet this benchmark, it affects his or her reappointment.

"If their delinquency rate for the H&P, the operative report, or the discharge summary is 10% or greater, according to the bylaws, they can only be reappointed for one year. If they do not bring all delinquency rates below 10%, they will not be allowed to reappoint," says Martin.

Convey importance of teamwork

The fact that the HIM department had administrative and medical staff leadership support and reappointment implications was what really contributed to the hospital's success, says Davis. "Administration has a lot to do with it because they're the ones who have stood behind us when we were struggling and when we were trying to perfect our process. And yes, we did make some mistakes, but we were always ready to say, 'Yes, we made a mistake,' " she adds.

Using a team approach to effect change has also worked well. "It really meets the intent. Everyone has

access to the H&P, and it takes the entire team. Surgeons are not allowed to move their patients into the surgical suite if the H&P is not on the chart," says Davis. "When one or two have slipped through, it is brought to the OR nurse manager's attention, who reinforces the need to comply to the rules with their staff. It has to be a team effort, and you just can't have a weak link."

"The system has to stay consistent. We cannot slack off," says Davis. "We have to keep up with the process in order for it to work. Consistency is the name of the game."

Several individuals, including those on the nursing staff, case managers, HIM staff members, and physicians, all play a role in ensuring timely H&Ps. "I have a real good rapport with the nurses on the nursing units and the surgery staff, as well as the case managers," says Williams.

And the hospital must be doing something right; after reducing its delinquent H&Ps, it began to focus on delinquent operative reports in 2003 and delinquent discharge summaries in 2005. Its delinquent operative report rate was at an all-time low of 0 for the third quarter of 2007, and its delinquent discharge summary rate is only 2%.

"I feel the majority of the medical staff works well with the department and takes pride in the overall improvement in the process," says Davis. ■

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Standards of the month

Address documentation requirements for emotional and behavioral disorders, diagnostic services, and care planning

Maintain compliance with PC.3.130, PC.3.230, PC.4.10

by Jean S. Clark, RHIA

This column is a continuation of our series of articles about The Joint Commission's (formerly JCAHO) documentation requirements. This month's column will discuss standards outside of the Information Management chapter in the Comprehensive Accreditation Manual for Hospitals that have documentation implications. Clark is the service line director for HIM at Roper Saint Francis Hospital in Charleston, SC, and author of the HCPro book *Information Management: The Compliance Guide to The Joint Commission Standards, fifth edition*.

PC.3.130: Patients treated for emotional or behavioral disorders

This standard addresses the needs of patients receiving treatment for emotional or behavioral disorders. A total of five EPs associated with this standard require documentation in the medical record.

- EP.1—The content for assessment and reassessments includes the patient's:
 - History of mental, emotional, behavioral, and substance-use problems, co-occurrence, and treatment
 - Current mental, emotional, and behavioral functioning as determined by a mental status examination
 - Maladaptive or problem behaviors
 - Psychosocial assessment
- EP.2—The required psychosocial assessment, based on patient age and clinical needs, includes information about the patient's:
 - Environment and home
 - Leisure and recreation activities
 - Religion
 - Childhood history
 - Military service

- Financial status
- Social and peer groups
- Sexual history
- Physical abuse
- Family circumstances
- Current living situation
- Social, ethnic, cultural, emotional, and health factors
- EP.4—Additional assessment, when appropriate, includes information about the patient's:
 - Vocational or educational background
 - Legal circumstances
- EP.5—Providers must document information regarding any community resources that the patient is currently using.
- EP.6—Based on the patient's age and needs, providers must perform:
 - A psychiatric evaluation
 - Psychological assessments, including intellectual projective, neuropsychological, and personality
 - Other functional evaluations of communication, self-care, and visual-motor skills

Tip: A documentation tool—paper or electronic—that prompts the caregiver to cover all of these points is the best way to meet this standard.

PC.3.230: Diagnostic services

This standard requires providers to perform diagnostic testing to determine the patient's healthcare needs.

There are three relevant EPs:

1. Testing is performed as ordered
2. Testing is performed in a timely manner
3. When a test requires clinical interpretation, appropriate information is provided

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Standards of the month

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Not only does this standard require documentation related to an order that the provider must sign, date, and authenticate, but it also has a time element for performing the order, as well as a reason for conducting the test.

Tip: Ensure that the medical staff has identified who can receive orders (e.g., lab technicians and nurses), as well as who can give orders (e.g., physicians and physician assistants).

Draft a policy that designates when providers must authenticate verbal/telephone orders according to state and federal regulations.

Remember that CMS recently changed its requirements for verbal/telephone orders. Orders must be dated, timed, and authenticated within 48 hours of when the provider rendered the order.

This standard also has two associated National Patient Safety Goals, which relate to verifying and measuring the timeliness of critical tests/values.

PC.4.10: Planning care, treatment, and services

This standard addresses planning care, treatment, and services for patients. It is often troublesome for organizations because its focus is the plan of care.

Although a plan for care, treatment, and services has long been included in the Joint Commission's standards, hospitals continue to receive recommendations due to problems with timeliness and incomplete plans of care. The medical record is the primary source for compliance with care planning at the time of an on-site survey.

Providers must individualize plans of care for each patient's specific needs. In particular, providers should:

- Integrate assessment findings into the care planning process
- Incorporate reasonable and measurable patient care goals into the care planning process
- Review and revise the plan of care on a regular basis
- Detail how they intend to render the care and treatment
- Document the plan, including how they carried it out, attained goals, etc.
- Monitor the effectiveness of the care planning processes
- Involve patients and families in the process

There are seven applicable elements of performance, two of which require measures of success (EP.12 and EP.13):

- EP.1—Providers must plan care to ensure that it is individualized to the patient's needs
- EP.2—Providers must base plans on assessments
- EP.6—Patients' needs, goals, time frames, settings, and services determine the plan of care
- EP.12—Evaluation of the patient is based on the goals and the plan of care
- EP.13—Goals are revised as necessary
- EP.14—Plans of care are revised as necessary
- EP.17—Restraints and seclusions must be limited

Tip: This standard calls for a good care planning tool that incorporates frequent revisions based upon patients' needs. The organization should identify where care plans are required and develop simple documentation requirements that cover the bullet points and identify the time frames for reassessments of their patients.

Working with patients and family members to establish and realize goals will go a long way toward compliance.

It is important to remember that this is indeed a time to keep it simple. Don't go overboard with plans and goals that you cannot achieve. ■

Questions? Comments? Ideas?

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News in brief

CCHIT certifies EHR products for acute care hospitals

The Certification Commission for Healthcare Information Technology (CCHIT) announced on November 5, 2007, that it has certified six EHR products designed for use in acute care hospitals. The four fully certified products include:

1. CPSI System 15 from Computer Programs and Systems, Inc.
2. Sunrise Acute Care 4.5 SP4 from Eclipsys Corporation
3. EpicCare Inpatient Spring 2007 from Epic Systems Corporation
4. Healthcare Management Systems 7.0 from Healthcare Management Systems, Inc.

Products receive full certification when inspections demonstrate their compliance with 100% of CCHIT's published criteria. The two premarket, conditionally certified products are ChartAccess 1.0 from Prognosis Health Information Systems and Soarian Clinicals 2.0CS with Siemens Pharmacy and Medication Administration Check 24.0 from Siemens Medical Solutions USA, Inc. Conditionally certified products receive full certification upon verification of their operational use in a hospital site.

HHS offers financial incentives to encourage EHR use

U.S. Department of Health and Human Services (HHS) Secretary Mike Leavitt announced October 30, 2007,

that a five-year demonstration project will use financial incentives to encourage small- to medium-sized physician practices to use EHRs. CMS will administer the demonstration project, which will be open to participation by as many as 1,200 physicians beginning this spring, according to the HHS press release. The program will provide financial incentives to physician groups that meet certain clinical quality measures using certified EHRs.

The project will require participating practices to use a certified EHR system to perform functions that can positively affect patient care, such as ordering prescriptions and clinical documentation, according to the press release. The system must be in place by the end of the second year and will require approval by a certification body officially recognized by HHS.

HHS proposes rules to advance e-prescribing

HHS has proposed rules to adopt several new standards it hopes will help spark usage of electronic prescribing and electronic medication history transactions, according to a November 13, 2007, CMS press release.

Not only does the Medicare Modernization Act of 2003 require CMS to adopt final standards for e-prescribing, but published reports state that approximately 530,000 adverse drug events take place among Medicare beneficiaries every year, according to the press release.

CMS hires contractor to conduct HIPAA security audits

CMS has established a yearlong contract with PricewaterhouseCoopers (PwC) to conduct security audits of covered entities.

PwC will target covered entities against which CMS has already received a complaint.

The confirmation comes on the heels of the Office of Inspector General (OIG) security audit of Atlanta-based Piedmont Hospital, which began in March 2007.

Although there has not been further information publicly available regarding the Piedmont audit, the OIG plans to conduct at least two more audits, says **John C. Parmigiani**, who contributed to the development of the privacy and security rules and is now president of John C. Parmigiani & Associates, LLC, in Ellicott City, MD.

In addition, **Karen Trudel**, deputy director of CMS' Office of Electronic Standards and Services, confirms that CMS has contracted with PwC to conduct security audits. The contractor might audit for overall security preparedness or for the implementation of corrective action plans in response to a complaint.

For more HIPAA security news, audit preparation advice, tips for compliance, as well as a look ahead at this year, see the January **Briefings on HIPAA** at www.hcmarketplace.com/prod-162.html. ■

Transcription spotlight

Consider front-end speech recognition to reduce transcription turnaround time, improve documentation quality

One CT hospital rallies physician support, uses software to make strides toward an EHR

As hospitals begin the arduous transition to EHRs, many are striving to find ways to make the process more manageable and less intimidating. For some, the solution has been speech recognition—a process that converts dictation directly into a text-driven electronic medium that is easily transferred to an EHR.

That's exactly what staff members at St. Francis Hospital and Medical Center, a 640-bed facility in Hartford, CT, had in mind when they began considering vendors.

"Our goal was to have all of our documentation created electronically, and we needed to have a mechanism for physicians to dictate H&Ps [history and physicals], consults, and progress notes," says **Carol Schuster, RHIA, MSM**, former director of HIM at St. Francis. "We also wanted to provide a mechanism to assist physicians who had illegible handwriting by providing a tool which would improve documentation and communication of their progress notes."

Dictaphone Healthcare Solutions, St. Francis' vendor of choice, provided an environment that accomplished these goals, including both front-end and back-end recognition. Front-end recognition immediately converts speech into text directly on the dictator's computer screen, providing real-time authentication and documentation completion. Back-end recognition allows a dictator to provide speech that is converted to text that is sent to an editor (other than the dictator) for corrections.

Note: For a related story about how one hospital implemented back-end recognition, see the December 2007 **MRB**.

Faster transcription turnaround time

Although St. Francis uses back-end editing in addition to traditional transcription, physician leaders also encouraged the implementation of a front-end optional. Users

can select either front-end or traditional transcription when they commence dictation. Dictaphone software allows users to switch back and forth between front-end (Enterprise Workstation) and back-end (EXSpeech) with one simple click in the user profile.

"When we were deciding on the type of dictation systems available, it became very clear that for a physician who works at the bedside, who is going from place to place, who is trying to synthesize data from all different sources, back-end is not acceptable," says **Thomas Freund, MD**, cardiologist and physician champion at St. Francis.

Back-end dictation implies a lag between the time the dictator provides information and when that information is entered into the chart, says Freund. "It makes no sense when you're trying to make decisions based on the people who are seeing the patients and want really sound data and guidance as to what to do next," he says. "Front-end is very different. We're talking about instant turnaround from the time that I complete my dictation until it makes it into the chart."

This is a definite bonus for physicians, says Freund. "The Dictaphone system is linked to the hospital's clinical system so that if a physician is at a remote site and want[s] to see what my progress note was from the day, or what my consults, H&P, or procedure report was from the day, it is available for review on our hospital system," he says.

The hospital's clinical system contains an icon that physicians can click on to indicate that they want to dictate a note. The physician then accesses a template, dictates into a microphone, reviews the note, and signs it. On some patient floors, the physician must print the note and insert it into the chart. However, the ultimate goal is to enable physicians to dictate from any location in the hospital and move the note to the chart electronically, Freund says.

Legible and detailed documentation

Both back-end and front-end speech recognition solve the problem of illegible handwriting. “I find handwriting to be an archaic art form,” says Freund. “To be fair, in a medical system, I don’t think there’s any place for a handwritten word. In addition, at the time of authentication, the transcribed report is automatically dated and timed, ensuring the organization’s ability to comply with CMS documentation requirements.”

Speech recognition software provides notes that are legible and that contain more supporting documentation. “Most of the handwritten progress notes I’ve seen don’t expound on things. It’s very cut and dry. So many of the notes that we’re now seeing are more accurate, more comprehensive, and there are more thoughts regarding the differentials and clear plans,” says Freund. “I think it makes for a more interesting note for people who are reading it. I think that’s a good thing in medicine; to be thoughtful and to document your thoughts.”

This added documentation is crucial in the EHR world, says **Peter Durlach**, senior vice president of marketing and product strategy for Dictaphone Healthcare Solutions, a division of Nuance Communications in Burlington, MA. “The reason that they do these notes, in addition to saving time, is that you’re seeing

a tremendous pressure to provide a level of documentation in EHRs in order to not only provide good care, but in order to justify your reimbursement level for an E/M code for an office visit,” he says.

Insurance company holdbacks provide yet another reason for more in-depth documentation, says Durlach. “If things aren’t documented in a way that is defined by the insurance company—which includes these in-depth narrative descriptions of the encounter—the insurance company will actually hold back reimbursement percentages that flow back to the institution and the physician,” he says.

Speech recognition drawbacks

Despite its ability to help improve documentation quality and efficiency, speech recognition technology has some drawbacks. For example, persuading physicians to participate in mandatory training can present a challenge. “Some of the physicians did balk in the beginning because it takes so much time,” says **Donna Picano, RHIT**, physician and Dictaphone liaison for St. Francis. “But those who were committed and really stuck to it found that it did get easier.”

Physicians begin their training by reading a series of scripts to enable the system to recognize their voices,

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Understand the benefits of front-end speech recognition

Deciding between front-end and back-end speech recognition is ultimately an individual hospital’s decision, says **Peter Durlach**, senior vice president of marketing and product strategy for Dictaphone Healthcare Solutions, a division of Nuance Communications in Burlington, MA. “It’s up to the customer to decide. It depends on what the pressures are in the specific institution that they’re in,” he says.

For example, one hospital may want to reduce transcription costs and complete discharge charts in a timely manner, whereas another hospital’s goal is to reduce transcription turnaround time or provide more detailed documentation.

Durlach says that front-end recognition works particularly well in areas in which the turnaround time is crucial and

there is a high volume of physicians who provide services for others. “The classic cases are radiology and pathology—the diagnostic areas where the physicians provide a service to others physicians, and their product is basically the result of a test or imaging study,” says Durlach. Front-end works well because the ordering physician can read the test or study soon after it is conducted, he says.

Front-end also works well in areas in which a hospital may be deploying an EHR. In these cases, front-end speech recognition has been shown to significantly decrease the time required for documentation, increase the quality of the documentation, and improve physician adoption of the EHR system by eliminating data entry via the keyboard.

Speech recognition

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says Picano. Next, physicians complete mock reports and learn how to build shortcuts into their templates.

“The system continues to learn you, and you continue to teach it. The pronunciation guide is sort of like the way you treat your child who keeps on doing the same thing wrong,” says Freund. “You stop, you type the word that it’s missing, and then you [repeat] the word, and it tries to match that word to your verbal enunciation of it.”

“Teaching” the software can be a slower, though not impossible, process for physicians who speak quickly, slur their words, or for whom English is a second language. “It does require some bending and changing of how you enunciate. But if you keep training it, it learns,” says Freund.

Persuading physicians that this endeavor was worthwhile was no easy task. St. Francis was fortunate, however, because Freund volunteered as physician champion and saw the process through to fruition.

“I think that physicians who are involved with our project see the light at the end of the tunnel,” says Freund. “They see a much better product and a much better note that they can save and use as a template to modify for subsequent encounters.”

During its next upgrade, St. Francis hopes to incorporate patient information that remains consistent between visits—such as social history, allergies, and medication lists—into its speech recognition process, thereby eliminating the need for repetition. ■

This month’s idea

Ensure that your record retention policy goes beyond the HIM department, includes certification of destruction

Although record retention requirements vary from state to state, every hospital should establish a policy that describes its record retention procedures in detail.

And it’s not just about medical records, says **Rachel Reyes, RHIA**, HIM director at Driscoll Children’s Hospital in Corpus Christi, TX.

Driscoll’s policy also addresses record retention in other departments, such as accounting, administration, and finance.

“[It is essential to] make other departments outside of HIM aware of their responsibility in reviewing their files and retention periods,” says Reyes.

When drafting Driscoll’s policy, Reyes researched specific Texas Web sites relevant to the topic of record retention.

Specifically, she consulted the following when drafting her policy:

- HIPAA

- Texas Health and Safety Code, *www.capitol.state.tx.us/statutes*
- Civil Practice and Remedies Code, *www.capitol.state.tx.us/statutes/docs/CP/content/html/cp.002.00.000016.00.htm*
- *Texas State Records Retention Schedule*, third edition. *Texas Administrative Code*, Title 13, Chapter 6, Section 6.10

When records are destroyed, Driscoll Children’s Hospital requires individuals to complete a “certificate of records destruction form” to indicate that the contents of a particular box were destroyed at the department director’s request. The department director and corporate compliance officer must sign the form and retain it indefinitely.

See p. 11 for the excerpt of the hospital’s certificate of records destruction form. ■

This month's training tool

Learn the new 2008 CPT codes

Directions: Distribute this quiz to staff members to help ensure that they are reporting the new 2008 CPT codes. If you haven't already ordered your new *CPT Manual*, visit www.hcmarketplace.com/prod-5286.html to do so now.

Question #1

A physician uses photocoagulation to treat a 10-month old infant for extensive retinopathy. The infant was born preterm at 25 weeks gestational age. The physician performs the procedure bilaterally. Which of the following codes should you report?

- a. 67228
- b. 67228-50
- c. 67229
- d. 67229-50

Question #2

Which of the following codes should you report when a physician performs an online medical evaluation with a personal, timely response for an established patient?

- a. 98966
- b. 98967
- c. 98968
- d. 99444

Question #3

A patient undergoes a laparoscopic total hysterectomy. The patient's uterus weighs 250 g. The physician also removes the patient's ovaries. Which of the following codes should you report?

- a. 58150
- b. 58571

- c. 58552
- d. 58573

Question #4

Which of the following codes should you report for manipulation of the temporomandibular joint, therapeutic, requiring an anesthesia service?

- a. 21073
- b. 97140
- c. 98925
- d. 98943

Question #5

Which of the following codes should you report for an osteotomy, spine posterior or posterolateral, three columns, one vertebral segment of the lumbar region?

- a. 22206
- b. 22207
- c. 22214
- d. 22224

Question #6

A patient undergoes a procedure in which the physician converts a previously placed gastrostomy tube to a gastrojejunostomy tube. The physician performs the procedure percutaneously, using fluoroscopic guidance including contrast injections, then completes image documentation and a report. Which of these codes should you report?

- a. 49440
- b. 49441
- c. 49442
- d. 49446

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- 6. d.
- 5. b.
- 4. a.

- 3. b.
- 2. d.
- 1. d.

Answer key

a minute for the medical staff

Follow the MUSIC to ensure proper documentation



Dear colleagues:

Now that Medicare Severity DRGs (MS-DRG) are in their fifth month, most physicians and hospitals can probably agree that no other diagnosis has been more misunderstood than congestive heart failure (CHF).

As we know, the American College of Cardiology (ACC) defines HF as a complex clinical syndrome that can result from any structural or functional cardiac disorder that impairs the ventricle's ability to fill with or eject blood. The ACC further emphasizes that HF is not synonymous with cardiomyopathy or left ventricular dysfunction, and that these latter terms describe possible structural or functional reasons for the development of HF. The ACC consensus statement is available at <http://content.onlinejacc.org/cgi/reprint/46/6/e1>.

Like the ACC, ICD-9-CM stipulates that physicians determine whether symptoms, such as pulmonary or peripheral edema, exercise intolerance, or orthopnea, are truly due to HF and, if so, the degree of severity, whether there are any underlying or precipitating pathologies, and to what extent any complications have ensued. Following the mnemonic MUSIC (manifestations, underlying cause, severity, instigating or precipitating causes, and consequences or complications) can help us improve our documentation and make our coders, case managers, and quality analysts happy.

Manifestations

When discussing CHF, consider whether the pulmonary or peripheral edema is indeed cardiogenic. Noncardiogenic pulmonary edema may result from pure fluid overload (e.g., dialysis noncompliance or

acute renal failure), noxious gas inhalation, acute respiratory distress syndrome, or hypoalbuminemia. If the patient has heart disease, ICD-9-CM assumes that all pulmonary edema is cardiogenic unless explicitly stated otherwise. Likewise, peripheral edema can result from chronic or end-stage kidney disease, cirrhosis, hypothyroidism, or other endocrine disorders. When we describe the exact cause of noncardiogenic peripheral or pulmonary edema, explicitly stating it as such, this usually results in a higher relative weight.

Ventricular dysfunction is not HF unless the physician declares it as such. Should HF exist, ICD-9-CM subdivides it according to anatomy and muscle function. Right HF manifests as jugular venous distention, peripheral edema, and a hepatojugular reflux. Left HF presents with pulmonary edema and paroxysmal nocturnal dyspnea. Many physicians document left HF with pulmonary edema, but they fail to do so with right HF. Emphasizing right HF as the result of cor pulmonale, cardiac tamponade, or isolated right ventricular infarction adds severity.

Physicians must describe HF as systolic, diastolic, or both on every admission or visit to obtain maximum severity in risk adjustment and MS-DRGs. Characteristics of patients with systolic and diastolic HF are outlined in *The New England Journal of Medicine*, Vol. 348, pp. 2007–2018, which is viewable after a free registration at <http://content.nejm.org/cgi/content/full/348/20/2007>. Most HF patients have a combination of systolic and diastolic HF; thus, describing them as likely having such is clinically congruent.

Underlying cause

Coders must know the underlying cause of HF to assign the correct code. Typically, an underlying

congestive cardiomyopathy is present; however, diabetic, hypertrophic, hypertensive, ischemic, restrictive, or other combinations exist. Some physicians may describe temporary acute HF as myocardial “stunning” or “injury.” In this circumstance, unless we describe its etiology, and the fact that acute systolic or diastolic HF is present, these terms have little effect on an MS-DRG. Likewise, we must use the word “cardiomyopathy” rather than “heart disease” if we are to increase severity in MS-DRGs.

As noted above, pericardial, endocardial, or great vessel disease can cause HF. Sleep apnea can result in respiratory failure and pulmonary hypertension, which leads to HF. Cardiac tamponade, cor pulmonale, and malignant hypertension are often not linked to the acute or chronic systolic or diastolic HF they cause; however, if our documentation links them, this will add severity.

Severity

For years, physicians have used ICD-9-CM code 428.0 (Congestive heart failure) to describe all of their patients with compensated and decompensated HF. As a result, MS-DRGs now assume that all patients with CHF (reported with code 428.0) are equal and do not require additional resources.

When a patient has compensated HF that incurs additional cost or risk, the physician must now explicitly document “chronic” HF, as well as its systolic or diastolic designation, to qualify as a complication/comorbidity (CC) under MS-DRGs. We must explicitly document decompensated HF as “acute” or “acute on chronic” systolic or diastolic HF to qualify as a major CC (MCC) under MS-DRGs. Omitting the systolic or diastolic designation results in a coder’s assigning code 428.9 (Heart disease, unspecified) for the case. Unfortunately, code 428.9 has negligible severity under MS-DRGs.

Remember that documenting the term “dysfunction,” or only documenting the ejection fraction (EF),

such as EF of 20%, does not indicate that the heart has failed. We must specify that the heart muscle has failed, especially when diuretics, digoxin, beta blockers, and afterload reduction are used to prevent decompensation. Documenting in this way helps to ensure that we correctly capture patient severity.

Instigating or precipitating causes

HF is the most common reason for Medicare patient hospitalization. Ask yourself why the patient developed acute (on chronic) systolic or diastolic failure. Did he or she possibly have a non-ST segment elevation myocardial infarction, develop acute renal failure (a recent rise in serum creatinine of > 0.3 mg/dl), sustain a pulmonary embolus, mishandle his or her medication, or increase his or her salt intake? If the patient developed atrial fibrillation, was the reason for the admission primarily the arrhythmia, or the acute systolic or diastolic HF that it precipitated?

Consequences or complications

Many HF patients do not require inpatient hospitalization. However, hospitalization becomes necessary when the patient develops complications or consequences from that HF.

For example, does the patient have chronic respiratory failure that requires home oxygen or acute on chronic respiratory failure evidenced by significant hypoxemia or respiratory distress that is present on admission? Is there acute renal failure on top of chronic kidney disease (don’t forget to stage it) due to renal hypoperfusion? Has the patient developed cardiac cirrhosis, venous stasis ulcers, or other chronic complications?

Warm regards,



James S. Kennedy, MD, CCS

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