

## SHARON'S CORNER

*Our current economic climate has raised havoc in the lives of many Americans. Jobs have been lost, savings and retirement income diminished, and healthcare reform is on the horizon. What it all means and what lies ahead is unknown.*

*What is a given is the resilience of one and all to overcome life's obstacles, challenges and insurmountable odds.*

*'We the People' of this grand nation, have come through in tough times before – often with better and stronger outcomes. As we approach the July 4<sup>th</sup> holiday, I hope everyone takes time to celebrate the true spirit of our country and its people!*



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### Hot Topics “the beat goes on” by Sharon L. Nicka, RN, CPC



In January of this year, Nicka & Associates sent out a memo notifying our clients of the 2011 updates and hot topics. I now realize we should have beaten the drum harder and louder to get everyone's attention. Sometimes, memos get lost in email spam, lost in interpretation or tossed into the nearest waste paper bin. Often times, the interpretation doesn't convey the importance intended!

While many hospital facilities and physician groups struggle with federal and state budget cuts that reduce revenue, we do not focus on the simple yet bigger problems; compliance and risk exposure. Our industry, both the hospitals and physician groups are under intense scrutiny and should sit up and take notice. Not only has the OIG been specific on their work plan targets, the RACs, MACs, ZPICs and CERTs have also identified areas of targeted RISK.

Documentation and coding risk are certainly not new, however the electronic medical record (EMR) can create new risk considerations. EMRs are here to stay — for those who have not transitioned to an EMR you will have to do so sometime in the near future. EMRs are vendor unique and each has their own set of pros and cons. Successful transition and implementation of an EMR requires collaborative chart flow design capabilities and comprehensive EMR specific documentation training. Some EMR prompts have caused the E&M levels to climb at an accelerated rate and the defaults and macros produce “clone-like” charts. This scenario creates compliance risk. Additionally, while some EMRs make it faster for physicians to document, they often produce a record that has prompted the provider on every symptom or contradiction of the patient's condition which in fact may suggest high level E/M services not justified by clinical facts.

Another area of compliance concern, both medical, legal and reimbursement is the medical decision mak-

ing or MDM as we know it. The MDM is a laser beam for code selection beginning with a well-documented HPI and continues until disposition. Most charts we see are well documented in terms of chart components, the HPI, ROS and PE (after all our EMR prompts us to complete).

However, when determining the complexity of establishing a diagnosis through management and thought processes, the EMR or provider documentation can fall short. Remember, it's the cognitive thought process the payers want to see to support and validate code assignments. What happened during the ED course? That's your MDM.

Lastly, signatures and authentication of orders are another targeted area. A legible signature is not only needed to identify the providers of service but is necessary to appropriately file a claim for payment of service. If the signature is illegible and your billing company sends the claim in before you electronically sign your chart or use a stamp to identify your signature it may be a false claim. Medicare requires that services provided/ordered be authenticated by the author “change request 66981 transmittal 327.” What this means in simpler terms is you must sign and date all orders when evaluating the patient and services provided. A good example is the chest pain patient that gets an EKG on arrival. The EKG is not billable unless you order it! Signatures must be legible and identifiable. Remember, if legibility is an issue you may be at risk for a false claim allegation!

Having said that, have you and your group looked at your compliance plan recently? Better yet, do you even have a compliance plan in place? If not, now is the time to look at the areas of risk exposure. Take a closer look at the details of your practice. Review the areas of interest both to the OIG and the “Alphabet Soup” list of auditors.

Consider the compliance risks above and diligently look at the big picture. Complete a risk assessment for you and your group – it is the right thing to do!

# TEAMWORK

by Jean Poe, RN, CPC & Margherita Rader, MEd

While facility and professional ED reimbursement are uniquely separate – an interdependence does exist that impacts the overall financial success of both sides of the emergency department equation.

## DOCUMENTATION

- Physician/provider documentation not only supports professional procedures but also supports billing these procedures to the hospital so that they can receive payment for resources and supplies used. Documentation of procedures are still coded and billed under the OPPS and reimbursed per the APC. It is important to document procedures clearly and concisely so that the coders can code the correct procedure to the professional AND facility claim.

## MEDICAL NECESSITY

- Both nursing and physician documentation supports medical necessity for the patient encounter. Under the Medicare program, all diagnostics ordered and completed must be medically necessary to help in making a diagnosis. Bottom line is medical necessity must be established for all services performed in the ED. It supports the resources used and any ancillary services performed for appropriate payment. Remember, documentation of re-assessments and response to treatment contributes to and substantiates the professional and facility E/M level and procedure code assignments.

## ORDERS

- All orders must be documented and signed! If there are no orders to support interventions used in the ED, it is not a billable service for either professional or facility services.

Team work is the name of the game - collaborative, cooperative efforts and communication between the providers and facility staff is critical to ensure overall compliance and reimbursement success!

## EFFECTIVE & EFFICIENT STAFFING FOR UC & FSED *(Part 1 of a 2-Part Series)*

by Margherita Rader, MEd

How do you deliver timely, quality patient care with efficient, effective, cost conscious use of staffing resources? The honest answer is ... it depends. While there is no magic standard staffing formula for Urgent

Care and Free Standing ED locations, there are key considerations that will assist you in improving efficiencies and identifying a successful staffing model for your location.

1. **Fundamental Factors:** Consider your site's location, facility structure, philosophy, services, demographics and community expectations. While delivery of quality care is a common goal for all, the 'look and feel' of services and staffing may vary from location to location based on these fundamental factors. What kind of staffing mix would align best with your location, philosophy and deliverables?
2. **The Role of the Physician:** Concentrate on the physician's' time and efforts to identify areas and services that truly require a

physician. Questions to consider are: Where does physician input make a material difference in outcomes? What changes could be implemented to support physician productivity? Consider augmenting physician staffing with use of Mid Level Providers.

3. **Alternative Staffing Options:** Take a look at each service that must be provided and consider staff positions with similar skill sets and cross train. Cross training of nurses with CT Techs, EMT/Paramedics and Medical Assistants is the key to success in balancing patient volume with quality services and cost effective staffing.

*(to be continued in next issue)*



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