Medical Staff Education

Driving Excellence in Healthcare Documentation Practices

The importance of complete and accurate documentation can not be overemphasized, especially in today's healthcare environment. The ongoing growth and challenges of the healthcare industry in the United States has resulted in a variety of new regulatory initiatives designed to promote improved patient quality of care outcomes and control future healthcare cost. Many of the new demands will affect healthcare reimbursement and are directly impacted by complete and accurate documentation.

A variety of education is provided including **Medical Staff Education, ICD-10 Physician Education, Hospitalist/Staff Physician Training and Physician Advisor Training.**

General Medical Staff Education

A board-certified physician of Huff DRG Review Services will provide a one hour presentation to various groups of physicians. The focus of the presentation is how physician documentation and inpatient coding affects the individual physician and their patients. Particular emphasis is placed on how coding is affecting economic credentialing and outcome analyses of individual physicians, as well as their own reimbursement. Additionally, specific suggestions are given to each specialty group regarding chart documentation that will enhance the accuracy and completeness of the coding of their inpatient records. Linkage of documentation to value based purchasing, EM coding, and re-admission rates is presented. Specific examples derived from the chart reviews are presented.

The medical staff presentations are conducted by physicians who have extensive experience in clinical practice and years of experience in dealing with the DRG system, and coding compliance issues. Various handouts, pertinent journal articles, and our proprietary reference book ***MS-DRG Documentation Handbook for Physicians*** is provided for each attendee. In addition, our app ***CDocT***™ is available for purchase for use on a mobile device.

ICD-10 Physician Education

Physician education and engagement regarding documentation issues are the some of the biggest challenges facing hospitals during the transition to the ICD-10 coding classification system. Our up close and personal physician education program for your medical staff focuses on tailored ICD-10 clinical concepts by specialty utilizing our multispecialty group of physicians with extensive clinical careers and who have been trained in ICD-10. Physicians working with physicians, on a peer to peer basis, and identifying your hospital's specific documentation issues by specialty, are unique approaches that no other company can reproduce.

Hospitalist/Staff Physician Training Program

Hospital based physicians are participating in an ever increasing percentage of hospitalized patients at most institutions. As a result, inpatient coding is becoming increasingly dependent on the documentation by this group of physicians. To assure the accuracy of the case-mix index and severity profiles at a facility, this group needs to have a more detailed knowledge of the DRG management process than the average physician. In order to accomplish this, a special seminar is offered for the hospital based physicians. This same program is also suggested for facilities that employ physician service line directors and physician assistants. Special documentation seminars for specific specialties can be provided for these groups in addition to the hospitalists.

- Three-hour seminar to familiarize the hospitalists with the Prospective Payment System and how appropriate chart documentation impacts the physician as well as the hospital
- Program can be provided on two consecutive ½ day sessions from which the Hospitalist can choose to attend based on their practice demands

Medical Staff Education *Continued*

The items discussed during the hospitalist training program include the following:

- How physician performance profiles and payment are impacted by hospital-derived ICD-9-CM code reporting
- Explanation of principal diagnosis definition and selection
- CC/MCC definitions and list
- In-depth discussion of specific clinical items which impact the specificity of inpatient code reporting such as sepsis/urosepsis, acute respiratory failure, diastolic/systolic heart failure, etc.
- Effects of documentation on ICD-10 code selections affecting DRG management
- Discussion of how "present on admission" designation impacts physician/hospital quality and payment
- Discussion of risk-adjusted 30-day mortality and 30-day readmission profiling.

Physician DRG Advisor Training

As an extended form of medical staff education, we offer a Physician DRG Advisor training program. A significant component to having a longstanding effective DRG management process is to have a physician champion. This physician will serve as a liaison between the health information department/clinical documentation improvement program and the attending physician staff as well as to aid in coding medically complex charts which impact the MS-DRG assignment.

- An outline of the physician profile and responsibilities of a physician advisor will be provided to assist you in identifying the right individual to serve in this capacity
- The training program is initiated with a three-day Physician DRG Advisor Instructional Seminar utilizing our proprietary training materials
- Physician DRG Advisor(s) receive extensive instruction regarding the Prospective Payment System and the techniques of chart abstraction using a sample of medical records
- Remote EMR monitoring of physician DRG advisor coding recommendations is offered and encouraged for a period of time to facilitate his training
- Phone consultation can be provided to supplement the chart review and assure that the physician advisor's efforts are appropriately applied