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Meet Betty B. Bibbins, MD, FACOG, CHC, CPEHR, CPHIT President & Chief Medical Officer, DocuComp LLC

Editor's note: This interview with Dr. Betty B. Bibbins was conducted by Jennifer O'Brien, HCCA Treasurer and Vice President Corporate Compliance, Allina Hospitals & Clinics in May 2007. Dr. Bibbins may be contacted by e-mail at BibbinsMD@DocuCompLLC.com.

Photo on this page and the cover by Don Feenerty.

JO: You have an extensive background that includes experiences as an educator, clinician, and administrator. Tell us a little about your health care experience and the journey that brought you to your current role.

BB: I earned my degree in nursing and then went to medical school in the 1970s. After completing residency, I was in private practice for a number of years. It was during this tumultuous time of change that I began to wonder about “other forces” that were beginning to impact my practice of medicine. I was frustrated when third-party payers were beginning to deny office visits and question patient care for reasons for which I couldn't find answers. It was also so intriguing that hospitals had medical records staff outside of the doctors lounge who would make us add specific documentation to charts before allowing us to see our inpatients. I began to question hospital administrators as to what was occurring, with some really vague non-responses. Honestly, I was aware of coding, but it never hit me that coding was based on

physician documentation. Long story short, eventually I was recruited by a NASDAQ-listed consulting firm to provide physician documentation education. I eventually rose to Sr. Vice President for Medical Administration and Compliance.

Initially, when compliance was added to my job description, I was truly angry at being given this “scut” task. The best thing that happened to me was that I received my introduction training to compliance through Dick Kusserow [former U.S. Attorney General] and Strategic Management Systems. When I learned exactly what compliance involved and why compliance evolved, learning from the former attorney general of the U.S. who implemented many of the original guidelines and laws, it became very obvious that this was a revolutionary paradigm shift for accountability in medicine—and it wasn't going away. It meant learning the letter of the law, as well as embracing the spirit of compliance.

In 1999, I founded DocuComp LLC. We are physicians who consult with hospitals and group practices to help attending physicians to understand and actively improve their documentation of medicine. I know that most physicians are practicing quality medicine, but if it isn't documented appropriately, then the true severity of illness is not captured and the utilization of health care services is not justified. My passion is to help other physicians to understand documentation and compliance as it relates to them and their practice of medicine.



JO: Your background demonstrates a commitment to improving physician documentation. What triggered the recognition that practicing physicians needed additional tools in this area?

BB: When the health care industry started to target physicians and hospitals for “fraud and abuse,” I really begin to wonder what this was all about. There were so many discussions in the 1990s about coding, and up-coding, that I truly wondered if it even applied to me as a physician. I began to research. The more I looked for information, the more information I found regarding coding, but not physician education. What could I do to help my coder/biller to perform her job “better”? As I learned more and more, it was quite evident that the coders were between a “rock and a hard place.”

What I saw were coders trying to help

their physicians without “bothering” them—meaning that the coders “knew” what the physicians were meaning to communicate, even if the explicit documentation was not in the record. The important detail of this scenario was that it was illegal to do this, and the government began to aggressively enforce their rules and guidelines’ regarding coding only what is “explicitly” within the medical record. To me, this meant that physicians had to be proactive participants the process of the appropriate documentation of patient care. Physicians are taught how to communicate clinically, but we have received little training in the documentation that is needed to support the coding of patient care and management.

As more and more discussions regarding the accuracy and correctness of coding were published, it was becoming more and more apparent to me that the “end product” was being impacted, and the foundation component (i.e., documentation) was almost not being brought into the equations.

It was evident that coders were coding what was strongly suggested in the medical record, even if it was not explicitly documented. The danger of this is that it is illegal. Physicians have to be explicit in their documentations. And one of the greatest challenges that I found was that physicians were minimally educated as to what the coding rules and guidelines required. That is when I knew that eventually physicians would come into the spotlight and that we could do it voluntarily or involuntarily.

JO: In addition to being the founder, you are the President and Chief Medical Officer of DocuComp LLC. Can you share the philosophy and focus of your organization?

BB: The mission of DocuComp LLC is for physicians to teach physicians, in office and hospital settings, how to maintain documentation compliance within today’s ever

changing regulatory environment.

Our major emphasis is to teach physicians what they need know to practice their medicine. We teach general documentation requirements, and then teach specialty-specific areas. This allows physicians to learn the information that they need to document their practice of medicine appropriately. This is going to be even more important as the Present-on-Admission, Medicare Severity-Diagnostic Related Group (MS-DRG), and Physician Quality Reporting Initiatives are implemented.

As physicians, we understand what is clinically taught in medical school and in residency. We also have learned what documentation/coding requirements are needed to communicate the care of patients.

DocuComp LLC endeavors to provide physician education in the areas of communicating patient medical care to third-party payers. Thus, the individual physicians, as well as their hospitals, receive the appropriate recognition for quality and efficiency of care provided.

JO: What do you find is the greatest frustration physicians have with physician documentation requirements?

BB: Lack of education and training regarding exactly what is expected of physicians regarding documentation of health care provided. Important aspects that need to be communicated are not only the practice of medicine, but the documentation/communication of the practice of medicine. Only the physician is at the bedside, so all overseers (Medicare and other third-party payers) have only the medical record to determine the quality and efficiency of care provided. All of the words of the medical record are converted, by health information managers(HIMs)/coders into codes. Only these codes are transmitted to third-party payers. Selected records are then reviewed to compare the

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“words in the charts” to the codes submitted as representative of explicit documentation. The words are either in the medical record, or they are not. Period.

One other challenge is that many of the rules and guidelines of coding may not make sense in clinical medicine. Physicians need to be educated to be what I call “bilingual.” As physicians, we learn quite well how to communicate clinically to other physicians. What we are minimally introduced to is how to document so that coders can capture the appropriate severity of illness. What physicians frequently interpret this to mean is “More is better, and I don’t have time to write more.” My response is “More is not what is needed. Efficient documentation of medical diagnosis and clinical judgment is needed—not just more words.” For example, we don’t need to copy the entire lab section in the progress note. If a patient has low serum sodium, the lab sheet has that finding. The most appropriate documentation, in the progress note, to acknowledge the finding, is to explicitly document the presence of “hyponatremia.” That is the clinical diagnosis that only a physician can diagnose. Low serum sodium cannot be converted to hyponatremia by the coder. This would be the practice of medicine by the HIM/coder. Period.

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In past generations, physicians wrote medical progress notes physician-to-physician. Today, it is not only physician-to-physician, but physician-to-coder-to-third-party payer. More external layers, that have different levels of communications, all stem from the physicians' medical record documentations.

JO: How do you integrate the regulatory and compliance obligations into the overall education you provide to physicians that is focused on improving the quality of documentation in the medical record?

BB: By making regulatory and compliance obligations the foundation from which all else is based. So many in health care are threatened, bored, and frustrated with the obligations, because they are interpreted to be "above and beyond" what may be needed, when, in fact, in today's health care environment, these obligations are a cornerstone. No matter how high the quality of care that is provided, if the documentation is not appropriate (i.e., the severity of illness does not justify the services provided) then there appears to be a mismatch of services to illness, which is interpreted as over-treatment with inefficiency, or under-management with inefficiency. Either of these interpretations may be inaccurate, but if there is no documentation to substantiate the appropriateness of care, what is present is what is reported. Period.

By putting the proper "face" on what compliance in documentation truly is, a misinterpretation of care is avoided.

JO: How do you connect with compliance officers in the work you do?

BB: The compliance officers that I interact with are the heart, soul, and consciousness of their facilities.

The number one interaction between me and facility compliance officers is usually "How do we get the medical staff engaged and responsive to the regulatory demands

which are placed on hospitals that are dependent upon physician documentation for survival?"

We share life experiences and discuss what interpersonal skills are needed to begin dialog. We connect in any format that is needed. Many times, we have discussions regarding situations that just need a compliance professional's perspective. Usually, just having someone to talk to, and bounce thoughts off of, is all that is needed to address whatever the challenge appears to be.

JO: As organizations transition to electronic medical records, what opportunities do you see around enhanced physician documentation?

BB: Electronic medical records and electronic health records have a very positive impact for documentation. They help to capture greater amounts of patient data and allow for faster and more thorough retrieval of medical information. They will be great for data entry—the greatest caveat being that computers cannot think for us. The quality of information input will determine the quality of data retrieved.

We, as physicians, must still be cognizant of appropriate, explicit documentation that specifically captures the patient's principal and secondary diagnosis, as well as our clinical judgment behind patient management. Unless this is appropriately documented, we will still get uncodable material that will not demonstrate the quality and efficiency of care that is provided to our patients.

Having an electronic format does not alter the accountability of the physician to be continually communicating relevant patient information. Personally, I still call it the "power of the pen" because it is not how the information is documented (whether on paper or electronically), it is just that the relevant information is communicated.

JO: What challenges do you see remaining or increasing around physician documentation in an electronic world?

BB: The fact that more and more emphasis is being placed directly on physicians to communicate in the language of documentation/coding. We have to learn, early in our medical education and training, that the clinical practice of quality and efficient medicine is important, but also the communication of the quality of medicine that is practiced is important. The burden of proof will be placed on the physician. Providing good health care will not be assumed, it will soon have to be proven.

With the electronic world, patient data will be mined, compiled, compared, and communicated to everyone in health care, including directly to our patients. Physician and hospital profiles will be publicly placed.

The above information should not be threatening to health care providers. All that is being asked is that what care is done, is appropriately communicated. We physicians have always thought that we were doing this... It is just that the world, and the rules of the world, are changing. We must keep up with the documentation changes—just like we keep up with the clinical changes in the practice of medicine. It truly is all the same.

JO: What compliance challenges do you anticipate as the industry moves to "Pay for Performance" standards?

BB: Quality of care may become more weighted by what ends up on Internet physician and hospital profiles than what may be truly practiced within an office or by the bedside. We have to find a way to balance the practice of medicine versus just the documentation of the practice of medicine.

JO: What advice do you have for compliance officers that might enhance their ability

to more effectively communicate with and educate practicing physicians?

BB: I have found that physicians need a venue to vent, discuss, and learn. Physicians are undergoing major upheavals in practice regulatory environments, and they frequently have very good suggestions regarding how innovations can be improvised.

I have found that through small, specialty-specific (surgical vs. non-surgical) group meetings, physicians can be informed of regulatory changes that impact them day-to-day. By presenting information that physicians need to improve their office and hospital components, informing them of changes that will directly impact them, and providing updates of how regulatory changes will impact them and their hospitals (such as Present-on-Admission documentation, and Medicare Severity-DRG [MS-DRG]), we help them adapt to changing requirements.

Also it is important for them to know that profiles are now being kept on all physicians and hospitals, with comparisons of quality of care being placed in Medicare Web sites beginning in the near future.

It is imperative that physicians and facilities work together to communicate the true, appropriate efficiency and quality of care being provided, because it will impact patient perception, as well as medical cost reimbursement in the future. This truly impacts all health care providers within each and every community.

JO: You have extensive experience as an educator. What tips do you have for keeping education and training effective and interesting?

BB: The single most important tip that I have as an educator is: Believe in what you say, and know what you are talking about. If you believe in what you are teaching, then it will come through in your voice and your actions. Others will sense your confidence

and feel your energy. Keeping up on all aspects of your topic will allow others to acknowledge your knowledge foundation, and you can have a spirited discussion with those who may not.

JO: You attended the Compliance Academy and are CHC certified. Why did you decide to attend the Academy and what did you gain from it?

BB: I have been a member of HCCA and attended Annual Institutes since 1998. I decided to attend the CHC Academy to reinforce my foundation in compliance. The information that I learn through *Compliance Today*, conferences, and one-on-one discussions are truly informative. They keep me in touch with updates and the nuances. The CHC Academy has allowed me to (intellectually) pull it all together.

JO: HCCA offers a number of educational opportunities. What can HCCA do to better meet the needs of physicians?

BB: HCCA is already addressing many educational needs of physicians, especially through its Physician's Practice Conference each year. This specifically addresses the needs identified in compliance for physicians.

The only other suggestion that I would have is to consider offering HCCA compliance sessions during American Medical Association (AMA) meetings or through various national/regional medical organizations. This will take compliance concepts to physician strongholds, and even offer CMEs for attendance. Physicians would then begin to see compliance as a mainstream component of their practices, and not as a separate entity or "burden."

JO: What do you see as the greatest challenge facing the health care industry in the next five years?

BB: Change. Over the next few years,

Medicare is going to be going through some of its greatest structural changes since being established. Within health care, we all need to keep up to date on the many changes that may be relevant to our areas of expertise. We need to learn the changes and attempt to embrace them for their positive attempts to keep our health care system solvent. This is where HCCA will continue to be a beacon of light for communicating the changes and helping us to understand nuances that we will see in the immediate future.

JO: How has being a member of HCCA helped you?

BB: HCCA has provided a support system and allowed me to continue to have a passion for compliance. All of us in compliance know that it can be a very lonely world out there, especially when there are challenges to address within our environments. Addressing these challenges, as well as helping others to understand why there is a challenge, may be a daunting, but they have to be addressed if our health care organizations are to be viable. HCCA has been there to provide an ear, a shoulder, a voice, and (at times) a Kleenex.

The most recent article that renewed my faith in the fact that I am doing what needs to be done, was Roy Snell's article on "Compliance professionals don't care" [February 2007, p. 22] Its essence (sorry Roy, if I misquote) is that as compliance professionals, we can't care if a law is right or wrong. (If you feel that it is wrong-get active with your legislator and get it changed.) We can't care if a law is fair or unfair (Ditto-get active and get it changed.) What we do care about is following the letter and the spirit of the law. Because if we don't follow the law we are breaking the law.

HCCA helps me to maintain a positive, strong, and relevant attitude towards all of my professional endeavors. ■