New Resident Orientation

Health Information Management
304-598-4109

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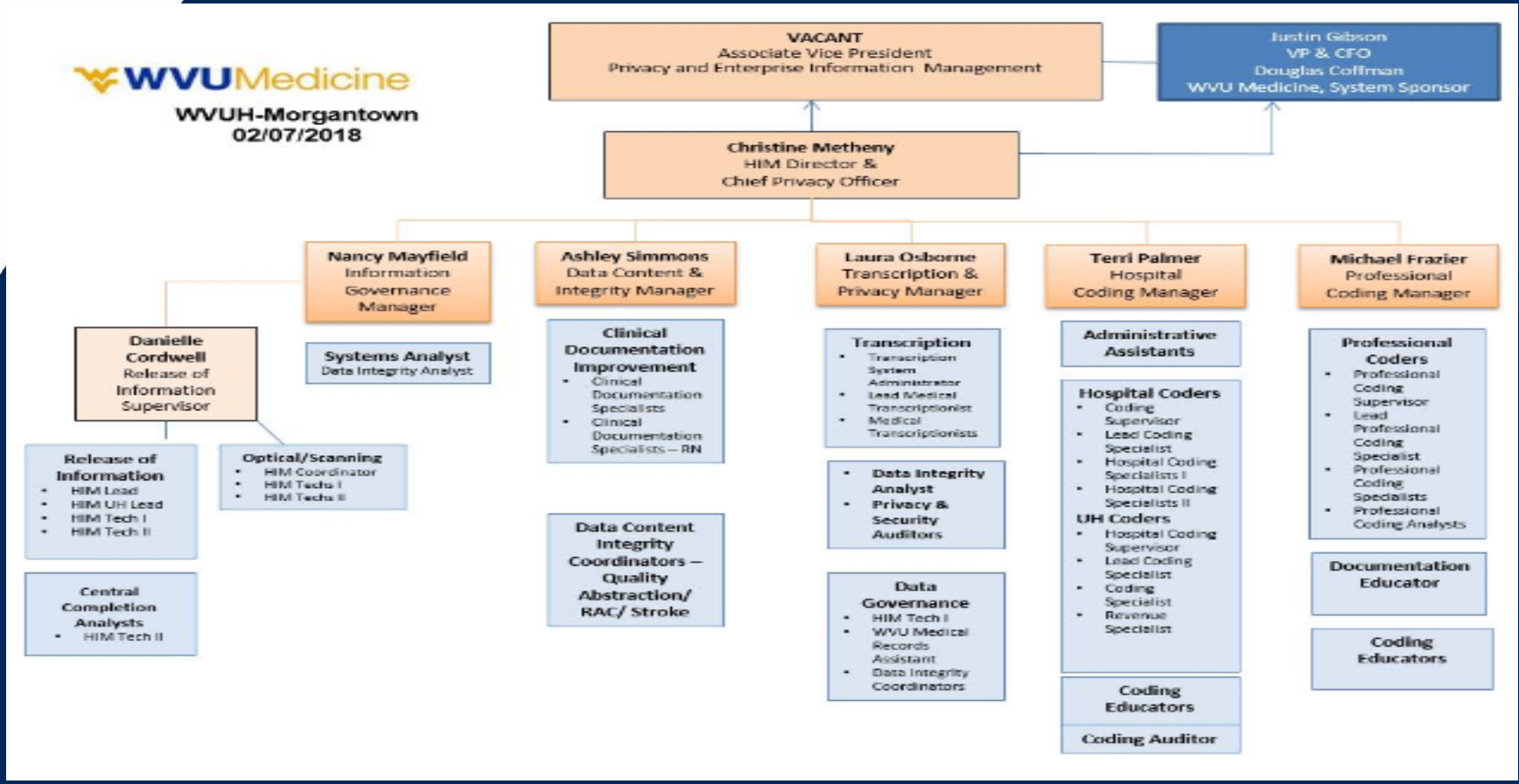
Director and Chief Privacy Officer

WVUMedicine

HIM-Located in WVU Medicine Operations Support Center
3040 University Avenue



Health Insurance Portability and Accountability Act

- Governs how WVUHC may use and disclose protected health information (PHI) for **treatment**, **payment** and **healthcare operations**.
- **Protected health information (PHI):** any personally identifiable health information that deals with a patient's past, present or future healthcare and anything that goes along with any of those items.
- **Minimum necessary:** HIPAA protects employees if they are using the minimum necessary information to perform their job responsibilities.
- **Safeguards required by HIPAA: physical**, **technical** and **administrative**
  - Audits are utilized to ensure employee compliance.
  - Patients have the right to know the identity of employee(s) responsible for any breach of confidentiality.

- Sanctions
- **Organization** – Can be fined millions of dollars

- **Individual** – Sanctions added with the passage of HITECH Act (Health Information Technology for Economic and Clinical Health Act) in 2009.
  - Up to $1.5 million in fines
  - Up to 10 years imprisonment

- A patient's presence at a healthcare facility is confidential.
- Information obtained as a result of your employment is confidential.
- All computer activity is monitored, do not share or post passwords
- CTRL ALT Delete and lock PC
- Be aware of who can overhear if you are talking on a hospital cell phone
- Elevators, cafeteria, public spaces be cautious of who can overhear
- Recycle bins for printed confidential information.
- Use rights and responsibilities from Policy IV.180.

Chart Completion

- Entries must be dated, timed, and signed. Your notes will entered in EPIC and require a co-signature.
- H&Ps must be completed within 24 hours of admission. If an H&P was performed less than 30 days prior, that information may be updated and utilized.
- Surgical H&Ps must be documented prior to the procedure.
- Discharge notes must contain medications, activity, diet, follow up instructions and discharge disposition.
- OP notes must be documented for all procedures immediately after the procedure. OP reports must be documented by the end of the day of procedure.
- Legibility and unapproved abbreviations are concerns that must be addressed in all documentation.
  - Examples: preceding and trailing 0 in medications can cause mistaken doses if the decimal point is not seen.
- Many Deficiencies are added in the system AUTOMATICALLY and must be completed timely.

Quality Documentation Program

- Used to capture the most complete and accurate documentation for the services provided. Thorough concurrent medical record review will be performed for designated payors.
- Queries, if needed, will be sent via inbasket message in EPIC. The queries may be for things like complexity of treatment, diagnosis conditions present on admission (perhaps in the case of an ulcer on a diabetic patient).
- If disagreeing you should note that on the electronic query.
- The query is not part of the legal medical record, so if you must document, you will have to go into the patient chart to document to satisfy the query and becomes part of the legal medical record.

Coding

CODING SPECIALISTS

Upon discharge of a patient, the record is then reviewed by Coding Specialist for diagnoses, procedures, and other pertinent outcome information for reimbursement, quality, and data integrity.

The Coding Specialists may contact you for additional documentation needed in the chart or for documentation clarification in the form of Queries. Any assistance provided or questions answered are greatly appreciated by the coding staff. Your prompt response will facilitate account billing and completion.

OUTPATIENT CODING

On outpatient accounts (labs, radiology, cardiology, etc) **DO NOT USE** Rule Out (r/o), possible, probable, suspected, or questionable (?) when recording your diagnosis.

The diagnosis should reflect the symptoms that have brought this patient in for the test such as sore throat, abdominal pain, etc.

Professional Coding Education

"If it's not documented… it didn't happen!"

- Details are important, be specific!
  - Diagnosis/Symptoms
  - Procedures
  - Reason for encounters
  - Treatment Plans
- Templates are helpful tools, however not all inclusive.
- Understanding Evaluation and Management (E&M) documentation guidelines will make an impact how codes are assigned for Professional Billing.
- Additional Coding/Documentation Education session will be scheduled by departments from the Professional Coding Educators:
  - Ashley Martin, CPC martinash@wvumedicine.org
  - Janice Tennant, RHIT janice.tennant@wvumedicine.org
  - Elizabeth Steele, CPC esteele2@wvumedicine.org

Birth and Death Registry

- **Birth Certificates**
- When a live birth occurs, the delivering physician **must** **complete** a Certificate of Live Birth form. The physician must sign and date (#9, #10 & #12) and also must complete the bottom section (#42a - #47).
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- If a live birth should become deceased, a Certificate of Live Birth **and** Certificate of Death are to be completed. A live birth is considered one having any Apgar at all.
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- **Report of Fetal Death (Stillborn)**
- When a fetal death occurs, the delivering physician must complete a "Report of Fetal Death" form **only** if the fetus is **350 grams or more**. A fetal death in which the fetus is 350 grams or more only requires a certificate to be filed if the family requests one. The physician must complete areas of CAUSE, CERTIFIER, MEDICAL AND HEALTH INFORMATION. Please send a copy to Medical Records.
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- **Certificate of Death**
- When a death occurs, the ***pronouncing physician*** must complete a "Certificate of Death" form. **The physician is required to sign, date and list cause(s) of death.** If all areas are not complete, Vital Registration will send this back to the Birth/Death Registrar to have the doctor complete. A special note concerning death certificates: the doctor who pronounces the death and signs the certificate MUST also PRINT his name at the bottom after the signature. If these are not completed properly, the **physician will be suspended**.

Release of Information

- An Authorization from the Patient or Patient's Legal Representative is ALWAYS necessary for the release of patient information!

- The only exception is when documentation of the primary care physician or referring physician is available in the system for our verification.
- Encourage Patient to sign up for MyWVUchart.com
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- Call 304-598-4113 with questions

Clinical Documentation Entry

- Several methods available for clinical information documentation into the patient record in EPIC
  - Direct Entry into Epic
    - Smart Phrases
    - Smart Templates
  - M*Modal
    - Fluency Direct – Voice Recognition
    - Fluency Direct and Partial Dictation
    - M*Modal Dictation/Transcription
    - M*Modal CDI Engage

Thank You & Welcome!

- Health Information Management * 304-598-4109