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MS HFMA PRESIDENT'S MESSAGE

Sandy Riley, CME
MS HFMA Chapter President

What a significant time in our industry! And, what an important time for HFMA to "Step UP" our commitment to our members, to provide timely, informative education and networking opportunities.

With the support of many of our chapter members, we are "Stepping Up" within our committees, our Leadership Board, and our Officers. The **Summer Workshop** in Philadelphia was evidence of the many hours of hard work that made the workshop such a success. Attendance was high, speakers were excellent, and the networking opportunities expanded.

HFMA's co-sponsored events with MHA also continue to be very successful. For example, the **Healthcare Reform Symposium** on September 30th captured an audience of over 100 attendees. Watch for HFMA emails notifying you of upcoming HFMA/MHA co-sponsored events.

The **Region 9 Meeting** in New Orleans continues its success November 14-16. Last year over 500 healthcare professionals came together to learn from the informative speakers that are always found on the Region 9 Meeting's agenda. If you haven't already made plans to attend, consider joining us.

MS HFMA is host for this year's **Tri-State Meeting** in Tunica, January 19-21. David Butler is Chair of this event and his committee is working diligently to compile another excellent panel of speakers. Mark you calendars to attend; you don't want to miss this one!

Lexie Fuller, President-Elect, and I recently attended the **Region 9 Fall President's Meeting**. Representatives from National HFMA and our Region 9 Executive enlightened us on HFMA endeavors, including the continued support and up-to-the minute **Healthcare Reform** updates. Our **Certification Testing** processes are changing January 1, 2011; these changes will assist in making the certification testing process easier. However, the process will incur only one overall test rather than two, so those of you who are interested may want to go ahead and gain certification before January 1st. HFMA's new **MAP program & MAP award** set new standards for revenue cycle excellence. It defines the indicators, offers resources to trace and improve performance, and honors excellence. MAP gives healthcare professionals the information needed to **Measure** performance, **Apply** evidence-based strategies for improvement, and **Perform** to the highest standards across the board. To learn more about the above endeavors, visit www.hfma.org.

I am so honored to serve your chapter this year. Thanks to all of you for "Stepping UP" and making this chapter the best it can be! See you in New Orleans,

Sandy Riley, CME

NEWS to NOTE

David Butler, CPA

HFMA has elected **David Butler**, CPA, as the 2012 - 2013 Regional Executive for Region 9, consisting of the Arkansas, Lone Star, Louisiana, Mississippi, Oklahoma, South Texas and Texas Gulf Coast chapters. This is an immense accomplishment not only for David on a personal level, but for the entire Mississippi Chapter. David will serve as the Region 9 Executive Elect during 2011 - 2012 and Region 9 Executive during 2012 - 2013. The role of the regional executive involves policy making and maintaining compliance authority over the Davis Chapter Management System (DCMS), monitoring the performance of chapters within the region, assisting chapter leaders in serving members, convening and organizing meetings of the regional leadership, fostering effective communications between HFMA National and the chapters, and expressing the needs and interests of the region's chapter leaders on the Regional Executive Council to the National Board and staff.

David has been a very active member of Mississippi HFMA for over 20 years. He has served our chapter well as our 2007 - 2008 President. He has also served the chapter as the Tri-State Chairman, 2005 - 2008, and as a Board member, 2003 - 2005. David is a recipient of the Follmer Bronze Merit Award, Muncie Gold Merit Award, Reeves Silver Merit Award and the Founders Medal of Honor. He is a partner in health care services of HORNE LLP, Ridgeland, Mississippi.

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NEWS to NOTE

RMB Inc., a Mississippi HFMA platinum sponsor, has been selected as one of the ***Best Places to Work in Collections***. Sandy Riley is Vice President of RMB Inc. and current President of MSHFMA. This program was created by *insideARM.com* and Best Companies Group.

This survey and award program identifies, recognizes and honors the best places of employment in the collections industry, benefiting the nation's economy, its workforce and businesses. This year, the *Best Places to Work in Collections* list is made up of 27 companies located across the United States.

Noah and Mom

Have you ever heard a speaker who told a story that touched your heart in a way that you would never forget? For many during the August 2009 MS HFMA Summer Institute, this speaker was **Laurian Scott**, the creator of The Olive Branch Fund: A Thisbe and Noah Scott Legacy, but Laurian says she is "first and foremost, always and forever, wife to John and mother to three beautiful children, Aslan, Thisbe and Noah." Laurian Scott delivered a moving, inspirational and heartbreaking keynote address during our chapter's summer institute. Since their daughter's "diagnosis" in the spring of 2006 with a pediatric motor neuron disease (MND), specifically a rare type called Brown- Vialetto-Van Laere (BVVL), the Scotts have been searching the world for doctors and researchers who may know something about the etiology and treatment of BVVL. On March 4, 2010 history was made for BVVL and motor neuron diseases alike with the discovery of the first candidate BVVL gene, identified as C20orf54, published in the American Academy of Human Genetics journal. The Scott's DNA contributed to the finding of this gene, along with at least 10 other participating families.

Thisbe and Mom

Visit http://www.bvvlinternational.org/BVVL_Research_Highlights.html for more information.

Jennifer Sinclair
St. Dominic Hospital

Jennifer Sinclair, Vice President of Finance and Chief Financial Officer at St. Dominic - Jackson Memorial Hospital, was featured as one of the 12 young healthcare executives (2010 Up & Comers), in the September issue of Modern Healthcare.

To listen to her interview, visit:

www.modernhealthcare.com/podcasts

Source: Modern Healthcare

September 2010

Member Highlight - Mark Lafontaine, Singing River Health System

Mark Lafontaine

Singing River Health System

I have been employed with Singing River Health System for the last five years. I have had the honor of creating a new revenue integrity department and am currently the manger of that department. Prior to working for Singing River Health System, I was employed with Memorial Hospital at Gulfport for 15 years. There I had the opportunity to work in several different capacities within the Patient Financial services department. That work experience has led me to this great opportunity at Singing River Health System.

As the Revenue integrity manager, I am currently responsible for many tasks within the Revenue cycle including the Accounts Receivable management of our 12 family practice clinics, 5 specialty clinics and 2 rural health clinics. I also oversee hospital denial management, underpayment recovery, pricing defensibility and the creation of any revenue enhancement opportunities.

This year is an exciting time within the MS HFMA chapter and I am very pleased to be a part of such a great organization that gives so much back to the Healthcare community. I am also honored to sit as a board member with so many others that share the same enthusiasm as I.

I am married to Jep Lafontaine and have three wonderful children, Elizabeth 11, Christian 9 and Emily 7, who give me a lot of joy and happiness. In my spare time I enjoy spending time with my kids, going to baseball games and watching the Saints.

In closing, I would like to say that I feel most of my success over time has been due to all of the great folks I have come to know within the Healthcare community. They have taught me and inspired me to work hard.

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Facing Billing Audits—
Don't get caught in the coming 'tsunami' of reviewes—be prepared instead

Lori Baker

HORNE LLP

By Keith L. Martin, As published in Physicians Practice

Lori is a manager in health care services at HORNE LLP. Her primary responsibilities include inpatient and outpatient billing and coding, performing coding reviews and conducting billing and coding seminars for physicians, clinical staff, administrative support staff, acute care facilities, inpatient psychiatric facilities and inpatient rehabilitation facilities. She also has served as an expert witness for Medicare and Medicaid hearings.

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It begins simply enough, when a piece of mail trickles into your office. What's inside, however, can lead to a downpour of paperwork and uncertainty in the form of a billing audit. With a renewed focus on healthcare fraud and Recovery Audit Contractors (RACs) now operational in every state in the U.S., you can bet a billing audit is in your future, says Michael J. Schoppmann, an attorney with Bridgewater, N.J.-based Kern Augustine Conroy Schoppmann who represents medical professionals in audit appeals.

"We've seen a tidal wave of billing audits in the last five to seven years," Schoppmann says. "In my opinion, there is a tsunami of billing audits to come in the form of the additional RAC audits."

Lori S. Baker, a consultant with Horne LLP, in Ridgeland, Miss., also assists physicians' offices and hospitals in the audit appeal process and concurs with Schoppmann's assessment on audit frequency. More and more offices are getting letters from Medicare/Medicaid, their insurance partners, and others with a request for records setting off the audit process.

"It is not *if* they are going to be audited, it is *when* they are going to be audited," Baker says. "We are seeing so many more [audits], so when they do get that letter, they need to have [a process] in place."

But there are ways to avoid the worst of it, according to our experts, who offer the following tips to prepare your practice for the coming storm.

Knowledge is power

Having worked for a company that performed integrity and billing audits, Connie Grosh says that preparation is the key. Grosh, now president and CEO of GroMed Medical Management and Consulting in Columbus, Ohio, advises practices to educate themselves on the integrity programs or claims review audit requirements with all partners, including insurers. Many if not all companies publish this information on their Web sites, she says.

This can include a time period on records to be reviewed, whether or not an auditor is allowed on site, and even if you can be audited in the first place.

Seek a helping hand

"I encourage every medical practice in the country — today — to immediately hire an external, outside consultant to look at billing, coding, and documentation practices," Schoppmann says. Just like hiring help with your taxes, getting the aid of someone who knows the ins and outs of billing audits is a must.

"[Practices] need to abandon the thought they can do it alone," Schoppmann says, and enlist some help.

He recommends using a consultant for what he calls a "snapshot audit" — looking at what is being done properly, what could be done better, and what could be changed at your practice. The result, he says, "lowers the risk of an audit exponentially."

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Dig deeper

Grosh also advises practices to "find the etiology" of the overpayments in collections and when they do, refund in a timely manner and make changes for the future.

"Be certain that your front-end process for obtaining and verifying insurance is very thorough and well executed," she says. "A little more time to verify eligibility and accurately enter the data in your system will save your practice much time, money, and scrutiny from payers."

Baker also advises being proactive and making moves today to help avoid tomorrow's audits. "Make the changes and make sure you have educated your providers on those changes," she says. "Do it now so in the future, you know you are doing it correctly."

Have a single point of contact

Before an audit letter even appears, both Schoppmann and Baker recommend appointing a person to take charge of the audit processes in your practice. If the letter has already arrived, find someone to lead the charge in your office right away.

If the left hand doesn't know what the right hand is doing, that's where you end up with an audit letter sitting on the desk … and you later discover you have three days to submit records," Baker says. "It happens and it happens a lot."

Schoppmann advises that this person not be a part-time employee, but someone "in more of a clinical, administrative, or bureaucratic position," who can examine the request and ensure the practice is fully involved in the process and will respond accordingly.

"If you give [the auditor] a poorly constructed, disorganized, poorly copied, incomplete record, that is what the judgment will be based upon, so you need to get someone to understand how to properly construct a proactive, pro-physician submission," he says.

Shed light on the questions

Prior to fulfilling a request for records, take a look at what you are sending and do a little educating.

Schoppmann says while many practices will simply make copies and send them to an auditor per the letter's request, he advises that before the records go out in the mail, you sit down with the records and conduct a self-review. You should ask questions including: Are there common themes? Are we coding without proper documentation? Are we billing too high for a service?

"By understanding what you are looking at, you can decide and be prepared to fight an audit or change things to limit the damage of the audit," Schoppmann says.

Baker advises that practices construct a cover letter to accompany records and either in that document or the records themselves, highlight auditing details.

"Spoon feed the auditor so they don't have to look for things," she says. "Say 'here it is.' You have enough ammunition to say this is what we bill and this is why we billed it. So that … it is black and white."

Preserve your paperwork

As with your own tax preparer, our experts recommend keeping a record of everything related to the audit. "Much like with the IRS, if you don't have the receipts, you won't get the deduction," Schoppmann says.

Following on the same theme, Baker advises making copies of everything you submit to the RAC, insurer, or other requesting party. "I have seen it way too many times [that] someone will come back and say we didn't get that," she says.

Baker is currently working on a case where an insurance provider claims 15 or 16 cases are missing documentation and the physician says they were sent, but lacks copies to prove his case.

She also recommends making copies of any shipping receipts or other proof of delivery to an auditor. Baker notes that with RACs, there is software that tracks sending information and other details, but for smaller offices, she simply recommends keeping a Microsoft Access or Excel database to track deadlines, details, and other information related to the audit.

Welcome New Members

Dianne N. Mott

Director, Organizational Excellence

St. Dominic Hospital

Larry M. Kroll

Territory Sales Manager

Craneware

Eugene Perkins

Senior Associate

HORNE LLP

Stephen Bomgardner

VP of Patient Care Services

St. Dominic Hospital

Scott McNair

Chief Financial Officer

Neshoba County General Hospital

Cynthia Hartmann

Director, IT Solutions Consultants

University of Mississippi Medical Center

Brenda Moon

Finance Director

Natchez Community Hospital

Jon C. Turner

Partner

BKD, LLP

Levearne Rias Torrey

Accounting Manager

University Physicians

John E. Herrington

Director—Finance

University Physicians

Black Tie & Blue Jeans

In conjunction with National HFMA's Theme for 2010, ***Step Up***, Mississippi HFMA is pleased to announce the **2nd Annual Step Up Awards Gala, *Black Tie* & Blue Jeans**, and to extend to you the opportunity to uniquely recognize those in your organization who have ***Stepped Up*** in 2010. The honorees will have the special privilege to be recognized in front of their peers from throughout the state of Mississippi.

WHEN: April 2011 - MS HFMA Summer Institute

WHERE: Beau Rivage Resort, Biloxi, Mississippi

Additional information will be forthcoming. Please forward your questions and inquiries to Charla Rowley, Awards Gala Committee Chair at:

charla.rowley@horne-llp.com

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Contact:

Warren Ladner, Membership Committee Chair

warren.ladner@hma.com

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CMS Changes Conditions of Participation (CoP) for Anesthesia Services

Robert Cox

Anesthesia Resources LLC

Robert is the managing partner at Anesthesia Resources, LLC an anesthesia billing, consulting and practice management firm based in Marietta. He is a frequent speaker and adviser to anesthesia and pain management practices, hospitals, vendor organizations, payer advisory boards, government organizations, health care graduate programs and health system boards. Mr. Cox is a frequent presenter at national healthcare meetings and he enjoys constant demand as a adjunct faculty speaker. He is a current member of the Georgia HFMA chapter.

The Centers for Medicare and Medicaid Services (CMS) recently revised the Conditions of Participation (CoP) for anesthesia services which is outlined in Transmittal 59 dated May 21, 2010. This article outlines the major compliance challenges associated with the new CoP and solutions to help hospitals assess vulnerabilities in anesthesia and sedation services.

The revised guidance added a significant amount of new language to the old guidelines. In summary, the revised language addresses the following four (4) areas:

1. **Types of Anesthesia Services**: The revised guidance provides definitions of the various types of anesthesia related services (i.e. general anesthesia, regional anesthesia, monitored anesthesia, topical/local anesthesia, minimal sedation, moderate sedation) and indicates whether they involve the administration of "anesthesia".

2. **Administration/Supervision Requirements**: The revisions provide additional guidance regarding who may administer anesthesia and the supervision requirements of non-physician personnel, specifically Certified Registered Nurse Anesthetists ("CRNAs").

3. **Pre and Post anesthesia evaluations**: The revisions refine the interpretive guidelines by explaining the requirements for pre and post anesthesia evaluations.

4. **Intra-operative Reports**: The guidance indicates the minimum elements required under the current standard of care for an anesthesia intra-operative report or record.

Part 1: Defining Anesthesia and Related Services

The new changes clearly define both anesthesia and sedation, borrowing from definitions found in the American Society of Anesthesiologists' (ASA) most recent set of practice guidelines (Anesthesiology 2002; 96:1004-17), summarized here:

- Anesthesia involves the administration of a medication to produce a blunting or loss of pain, voluntary and involuntary movement, autonomic function, and memory and/or consciousness.
- Patients often require assistance in maintaining a patient airway, or correcting depressed spontaneous ventilation due to drug-induced depression of neuromuscular function.
- Cardiovascular function may be impaired.
- Anesthesia is used for those procedures when loss of consciousness is required for the safe and effective delivery of surgical services.

Monitored Anesthesia Care (MAC) includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia. Deep sedation/analgesia is included in MAC.

- In Deep Sedation/Analgesia, patients cannot be easily aroused but respond purposefully following repeated or painful stimulation.
- The ability for the patient to independently maintain breathing function may be impaired.
- Patients may require assistance maintaining an airway, spontaneous ventilation may be inadequate.
- Cardiovascular function is usually maintained.
- Deep sedation/analgesia includes the use of propofol.
- Must be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).

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CMS Changes Conditions of Participation for Anesthesia Services - Cont.

Regional Anesthesia is the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves used when loss of consciousness is not desired, but sufficient analgesia and loss of voluntary and involuntary movement is required.

- Regional anesthesia includes epidurals, spinals and other central neuraxial nerve blocks.
- Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, administration of regional and general anesthesia must be delivered or supervised by a practitioner as specified at 42 CFR 482.52(a).
- Epidural or spinal route for the purpose of analgesia—during labor and delivery—is not considered anesthesia, and therefore it is not subject to the anesthesia supervision requirements.
- If C-section is necessary, anesthesia supervision requirements would apply (42 CFR 482.52(a)).

Tips for Compliance

To comply with this section of the regulations, changes in policies and practices may be necessary. Assuring that all areas have been addressed is the only way of avoiding violations on future surveys. Begin by assuring that the following items have been established in policy and practice:

- Align the definitions for anesthesia and sedation with those supported by CMS and ASA.
- Define where the different levels of anesthesia can occur and under what circumstances.
- Evaluate the level of compliance with the requirements at each location where anesthesia and sedation is administered.

In contrast, the new CoP also outline those services not subject to the anesthesia administration and supervision requirements (42 CFR 482.52(a)):

Topical or Local Anesthesia or Minimal Sedation in which:

- Patients respond normally to verbal commands.
- Although cognitive function and coordination may be impaired, ventilation and/or cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") in which:

- Patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.
- No interventions are required to maintain a patient airway.
- Spontaneous ventilation is adequate.
- Cardiovascular function is usually maintained.

Rescue Capacity

- Hospitals are required to ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than initially intended.
- Intervention by a practitioner with expertise in airway management and advanced life support is required.
- The qualified practitioner corrects the adverse physiologic consequences of the deeper-than-intended level of sedation and returns the patient to the originally intended level of sedation.

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Calendar of Events

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CMS Changes Conditions of Participation for Anesthesia Services - Cont.

Part II: Anesthesia Administration and Practitioners

Anesthesia Administration

According to the regulations, only the following practitioners can administer anesthesia:

- A qualified anesthesiologist
- A doctor of medicine or osteopathy (other than an anesthesiologist)
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law
- A certified registered nurse anesthetist (CRNA), under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed, unless in an opt-out state (As of July, 2009, opt-out states include CA, IA, NE, ID, MN, NH, NM, KS, ND, WA, AK, OR, SD, WI, MT.)
- An anesthesiologist's assistant, who is under the supervision of an anesthesiologist who is immediately available if needed.

The Medical Staff bylaws or rules and regulations must include criteria for determining the anesthesia service privileges to be granted to an individual practitioner and a procedure for applying the criteria to individuals requesting privileges for any type of anesthesia services, including those not subject to the anesthesia administration requirements (sedation). The hospital's Governing Body must approve the specific anesthesia service privileges for each practitioner who furnishes anesthesia services, addressing the type of supervision required, if any. The privileges granted must be in accordance with state law and hospital policy.

The type and complexity of procedures for which the practitioner may administer anesthesia must be specified in the privileges granted to the individual practitioner.

When a hospital permits operating practitioners to supervise a CRNA administering anesthesia, the Medical Staff bylaws or rules and regulations must specify for each category of operating practitioner, the type and complexity of procedures that category of practitioner may supervise. However, individual operating practitioners do not need to be granted specific privileges to supervise a CRNA.

Tips for Compliance

To comply with this section of the regulations, changes in policies and practices may be necessary. Assuring that all areas have been addressed is the only reliable way of avoiding violations on future surveys. Begin by assuring that the following items have been established in policy and practice:

- Define what privileges are required for each level of anesthesia services, including sedation and monitored anesthesia care.
- Align policy and practice regarding the appropriate level of supervision for non-physicians permitted to administer anesthesia under supervised situations.
- Define criteria for determining the anesthesia services privileges for individual practitioners, including those that may administer only sedation.

If the hospital will permit anyone other than an anesthesiologists to supervise a CRNA administering anesthesia, specify in the Medical Staff bylaws or rules and regulations, for each category of operating practitioner, the type and complexity of procedures that category of practitioner may supervise.

- On an ongoing basis, assure that the practices occurs as designed:
- The governing body shows approval of the specific anesthesia privileges granted to individual practitioners and any type of supervision required.
- If operating practitioners are allowed to supervise CRNAs, then define the privileges required to permit this supervision and the type and complexity of procedures where allowed.

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CMS Changes Conditions of Participation for Anesthesia Services - Cont.

Part III: Responsibilities of the Anesthesia Department

Responsibilities of the Anesthesia Department

While many hospitals view Anesthesia Services as primarily a Medical Staff department, like Surgery or Gynecology, the CMS Conditions of Participation view it as similar to departments like Radiology, Food and Nutrition, and Rehabilitation Services. The emphasis lies in the provision of services rather than the positioning or reporting responsibilities set forth on an organizational chart. The Anesthesia Services department provides anesthesia, sedation, and analgesia as defined earlier. Staffing includes anesthesia providers, along with technicians or support staff members who assist in the management of the department. As a department of the hospital, Anesthesia Services has similar responsibilities for meeting the needs of patients, and improving care through the QA/PI process. Additional responsibilities are specified in the regulations.

Responsibilities of Anesthesia Director

The regulations require the Medical Staff to establish criteria for the qualifications of the Director of Anesthesia Services. The Director of Anesthesia department is responsible for:

- Developing policies and procedures governing the provision of all categories of Anesthesia Services, including under what circumstances an MD or DO who is not an anesthesiologist, a dentist, oral surgeon or podiatrist is permitted to administer anesthesia
- Defining the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services
- Integrating Anesthesia Services into the QA/PI program of the hospital

Required Policies and Procedures

The goal for delivery of anesthesia services, centers around consistent use of resources to meet patient needs. Policies outline these expectations, and at minimum, hospitals must address:

- How Anesthesia Services needs will be met at all locations
- Clearly defined pre-anesthesia and post-anesthesia responsibilities
- Delivery of anesthesia services consistent with recognized standards—well designed policies would likely include:
    - Patient consent
    - Infection control measures
    - Safety practices in anesthetizing areas
    - Protocol for supporting life functions (cardiac, respiratory and hyperthermia emergencies)
    - Reporting requirements (errors, incidents)
    - Documentation requirements (both in the medical record and other sources such as narcotic logs)
    - Equipment requirements (monitoring, inspection and maintenance)

Tips for Compliance

To comply with this section of the regulations, changes in policies and practices may be necessary. Begin by assuring that the following items have been established in policy or practice:

- Assure that Medical Staff documents clearly spell out the required items for privileging physicians and others practitioners for the types of anesthesia and complexity of procedures.
- Review policies to assure that each item noted in the Conditions of Participation can be found. If policies reside in a general or nursing manual, consider utilizing a quick reference sheet to be able to quickly identify the location and content required by the regulation.
- Conduct an internal review of all sedation and anesthesia locations to assure consistent standards among all locations. Utilize pharmacy billing records, if needed, to identify all areas where sedation or anesthesia may be provided, particularly in off-site locations.

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CMS Changes Conditions of Participation for Anesthesia Services - Cont.

Part IV: Pre- and Post-anesthesia Evaluation

Pre-anesthesia Evaluation

The interpretive guidelines for pre-anesthesia evaluation and post-anesthesia assessment have changed somewhat in terms of how hospitals provide surgical services, both on an inpatient and outpatient basis.

For the pre-anesthesia evaluation, some of the expectations continue to apply:

- A pre-anesthesia evaluation must be performed for each patient who receives general, regional or monitored anesthesia.
- While patients receiving moderate sedation be monitored and evaluated before, during, and after the procedure by trained practitioners, a pre-anesthesia evaluation is not required because moderate sedation is not considered to be "anesthesia," and thus is not subject to this requirement. Hospitals may choose to require the assessment for an increased level of safety.
- The evaluation must be performed by someone qualified to administer anesthesia
- Delegation of the pre-anesthesia evaluation to practitioners who are not qualified to administer anesthesia is not permitted.
- Evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery or procedure requiring anesthesia services.

To provide further clarity, the interpretive guidelines now outline the expected components of a pre-anesthesia evaluation, which includes, at a minimum:

- Medical history, including anesthesia, drug and allergy history
- Interview and examination of the patient
- American Society of Anesthesiologists (ASA) classification
- Any potential anesthesia problems, (e.g., difficult airway, ongoing infection, limited IV access)
- Additional pre-anesthesia evaluation, based on patient condition (e.g., stress tests, labs, additional specialist consultation)
- Plan for anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia

In addition to the documentation requirements for pre- and post-anesthesia assessments, intra-operative documentation requirements are spelled out in the regulations. They note, however, that an intra-operative anesthesia report is not required for patients undergoing sedation, since sedation is not considered anesthesia.

Post-anesthesia Evaluation

Post-anesthesia evaluation requirements have been much discussed in the last several years. While the requirements seem simple and straightforward, they are open to interpretation that may conflict with the spirit of the standard. According to regulation §482.52(b)(3):

- A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia.
- Evaluation must be completed no later than 48 hours after surgery or a procedure requiring anesthesia services.
- Evaluation must occur any time general, regional, or monitored anesthesia has been administered.
- The evaluation must not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, (e.g., answer questions appropriately, perform simple tasks, etc.).
- The evaluation must occur either in the PACU/ICU or in another designated recovery location.

The key topic of discussion has been the setting and timing of the evaluation. While the regulations do not prohibit the evaluation from taking place the minute that the patient is moved to the PACU, the patient's condition dictates when the evaluation occurs—not the work flow or convenience to the anesthesia practitioner. For instance, a patient receiving a regional block may be assessed in short order as the time for extension of the anesthesia has passed by the time the patient enters the PACU. However, it would be inappropriate to evaluate a patient emerging from general anesthesia immediately following entry into the PACU as the patient could slip into unconsciousness again.

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CMS Changes Conditions of Participation for Anesthesia Services - Cont.

Post-anesthesia evaluation must at least include:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation
- Cardiovascular function, including pulse rate and blood pressure
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Postoperative hydration

The evaluation needs to take place at a time when the patient has "sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation." This determination must be made by the anesthesia practitioner.

In reality, there are three assessments that commonly occur following procedures that involve anesthesia:

- Evaluation for readiness for lower level of care—Completed by Nursing,
- Evaluation for readiness for discharge—Completed by Nursing against a protocol developed by Anesthesia; includes additional factors representing ability of patient to care for self (eat, urinate, walk)

Post-anesthesia care evaluation—Evaluation dictated by the Conditions of Participation; requires professional judgment of an anesthesia provider. Determines patient's degree of recovery from anesthesia and presence/absence of complications. Cannot be delegated, except to another anesthesia provider.

Tips for Compliance

The key to compliance within the pre- and post-anesthesia evaluation process is under standing the level of compliance in each anesthetizing location and addressing gaps in compliance. While document review is an important first step, it may not provide insight into the timing of the post-anesthesia assessment and the important factor of the evaluation occurring when the patient has "sufficiently recovered." To avoid common traps that result in citations during CMS survey, assure that the following items are included in the medical record review:

- A completed pre-anesthesia assessment that includes all items noted in the regulations
- A completed post-anesthesia assessment that includes all items noted in the regulations
- A criterion that compares Nursing documentation of the level of patient's wakefulness at the time of the completion of the post-anesthesia assessment—look for conflicting accounts between the anesthesia note of "recovered" with that of Nursing's documentation

The information contained in this advisory is for general educational purposes only. It is presented with the understanding that neither the author nor Anesthesia Resources, LLC is offering any legal or other professional services. This article provides a guide to the most important aspects of the new regulations. When modifying your current policy and practices, please refer to the full text of the regulations.

[1] CMS Transmittal # 59 condition of participation for anesthesia services in the Medicare and Medicaid programs.

[2] The definitions are generally based on those provided by the American Society of Anesthesiologists.

[3] States have the ability to opt-out of the general MD/DO supervision requirement for CRNAs. A list of States that have exercised their opt-out option, and which are exempt from the requirements for physician supervision of CRNAs under 42 CFR 482.52(a)(4), is available at http://www.cms.hhs.gov/CFCAndCoPPs/02_Spotlight.asp.

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Your Assistance Needed

CPAR Initiative & Development Committee

We are pleased to announce that the Mississippi Chapter of HFMA is considering implementing and offering the Certified Patient Account Representative (CPAR) Program. Our mission is to provide educational resources to enhance the knowledge, personal growth and development to Account Representatives in all healthcare professions. The purpose of the program is to educate as well as recognize those who have demonstrated fulfillment and proficiency in the revenue cycle field.

The Certified Patient Account Representative (CPAR) Program is an ideal training and certification program for:

- Patient Access Staff
- Patient Financial Staff
- Customer Service Staff
- Other Healthcare Professionals

Currently Alabama, Georgia, Tennessee, Florida, and South Carolina all have this successful program in place. The CPAR Program can lead to offering other certification programs for the Revenue Cycle Staff. As we continue to strengthen our chapter with this endeavor we are seeking individuals who would be interested in taking part in developing this program.

If you would like to become a part of this initiative and the CPAR Committee, contact Sandy Riley at:

SRiley@rmbcollect.com

HFMA's certification programs prepare you for increasingly responsible positions in the healthcare finance industry. Certification demonstrates your comprehensive understanding of healthcare financial management overall, as well as your proficiency in one or more specialty areas of healthcare finance. If you would like additional information on the levels of certifications offered by HFMA as well as changes to the Certified Healthcare Financial Professional (CHFP) exam effective January 2011, please click on the link below.

www.hfma.org/certification

David Williams

HORNE LLP

NOW IS THE TIME

NEW CERTIFICATION EXAM

EFFECTIVE JANUARY 2011

If you've ever thought about becoming a certified member there is no better time than the present. With all of discussions of health care reform and its impact on the financial aspects of healthcare, set your career apart with the additional designation as a certified healthcare professional.

The exam is currently structured with a CORE exam which tests the baseline knowledge of healthcare finance and a specialty portion in one of the following areas:

(1) Accounting and Finance

(2) Physician Practice Management

(3) Managed Care

(4) Patient Financial Services.

The Chapter has purchased study guides in its library to be provided to members upon request for each exam and the Chapter also hosts coaching courses throughout the year at our educational meetings.

The process for application, testing and certification can be found on the HFMA.org website or for further information contact David Williams, Certification Chair @ 601-326-1320 or david.williams@horne-llp.com

CONGRATULATIONS TO RECENTLY CERTIFIED MEMBERS!

JIM WADLINGTON, CPA, CHFP

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The mission of our chapter is to provide healthcare financial professionals in our state education and information to assist them with better job performance and career enhancement. We believe our organization is in the best position to provide this education and information and we intend to do that.

Our intent is to offer healthcare professionals a quality product and a value for their money. We intend to enhance the value of our meetings in several ways including making sure our programming is relevant, filling up our agendas with more hours and speakers, consistent communication, and by partnering with other groups to leverage our resources for better speakers, etc.

So how does this impact you? In order to keep our educational sessions at the highest level and also at an affordable price, we need your sponsorship commitment to subsidize those meetings. Your corporate sponsorship is important in insuring our success in meeting the educational needs for healthcare professionals in our state. The Corporate Sponsorship Program details the program, including costs and the various benefits you will receive as a corporate sponsor.

Your corporate sponsorship is key to the continued success of our chapter. Thank you for getting involved with our chapter and becoming a part of an organization with a strong tradition of excellence and service.

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Bill.nesmith@franklinservice.com

Dan Franklin
President and CEO

Franklin Collection Service, Inc.

PLATINUM SPONSORS HIGHLIGHT – MAGNOLIA HEALTH PLAN

Magnolia Health Plan is a Medicaid Coordinated Care Plan. Medicaid Coordinated Care Organizations (CCOs) provide comprehensive, coordinated healthcare services to improve quality and outcomes for Medicaid recipients, including those receiving SSI.

On October 1, 2010, the Division of Medicaid (DOM) announced federal approval authorizing the MississippiCAN program throughout the state of Mississippi effective January 1, 2011. The MississippiCAN program is focused on serving targeted high cost beneficiaries including the SSI, disabled children at home, working disabled, foster care and breast/cervical cancer populations. The key goals of the program are to improve access to needed care, provide a medical home and improve the quality of care for these high risk populations.

Magnolia Health Plan (Magnolia) is one of two health plans selected by DOM to administer outpatient benefits under this program. Magnolia is committed to establishing long-term relationships with providers to ensure Medicaid recipients – your patients – receive quality care. We engage providers to play an active role in working with us on such key areas as program design, quality improvement and pharmacy issues, just to name a few. Magnolia will be providing enhanced benefits to Medicaid patients above the standard Medicaid benefits/limits including: pharmacy prescriptions, additional physician office visits, vision care and certain screenings and preventive services. We are working through the Mississippi State Medical Association's subsidiary network Mississippi Physicians Care Network (MPCN) to contract physicians who are not participating through a hospital or PHO.

Magnolia is wholly owned by Centene Corporation which has been serving Medicaid members for 25 years and currently has nearly 1.4 million Medicaid members in 10 states. While Magnolia is able to draw upon Centene's national infrastructure, we are investing extensively in Mississippi with offices and employees to better serve our members and providers.

Magnolia® Health Plan

To learn more about Magnolia Health Plan and to become a participating provider, please contact:

Vanessa Adams

Director of Contracting

601.850.4859

vadams@centene.com

111 East Capitol Street, Suite 450

Jackson, MS 39201

Bowling Tournament – MS HFMA Summer Institute

lst Place Team - $160 (score: 715)

David Butler

Kathryn Walker ***individual highest score: 278***

Samantha Oberhausen

Brad Williams

2nd Place Team - $100 (score: 681)

Wayne Walters

Regina Bailey

J. C. Rouse

Wayne Dunn

3rd Place Team - $60 (score: 659)

Kyle Smith

Bill Nesmith

Mike Weeks

Mandy Alford

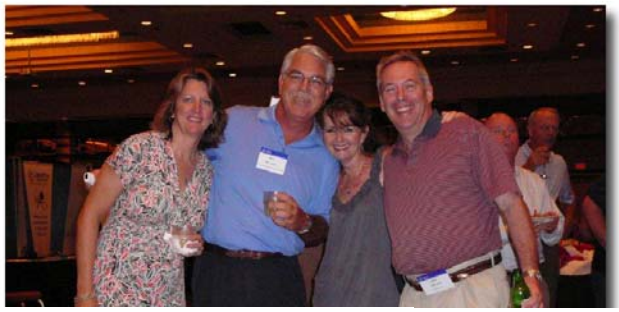
Last Place Team - $4 (score: 440)

Pat Riley

Arlie Ramsey

Bill Munn

Bowling Tournament – MS HFMA Summer Institute

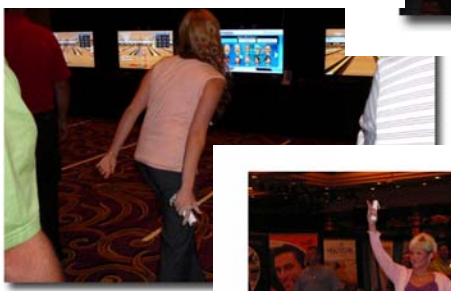










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EDITOR'S CORNER

Robin Long

Newsletter Editor

I hope everyone is enjoying the great weather as much as I am! Thank you for taking your valuable time to read our chapter newsletter and we hope you get something useful from it. Don't forget the upcoming Region 9 and Tri-State meetings in November and January. I hope to see everyone there, and keep smiling. ☺ Special thanks to Mike Weeks for capturing these memorable moments at the Wii Bowling Tournament! We had a great time and the pictures prove it!

We welcome your feedback on our newsletter. If there are topics you are interested in learning more about, please email us at rlong@hfsllc.com.

Robin J. Long

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healthcare financial management association

MISSISSIPPI Headlines

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The Official Newsletter of Mississippi Chapter of HFMA

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