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OUR MISSION

The Mission of the
Michigan Health Information
Management Association
is to be Michigan’s expert voice
on health information.

Michigan Health Information Leaders

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CDIP Coding Round Tables
 SUBMITTED BY: SHEILA BOWLDS, MBA, RHIA

On December 3rd and 5th, two CDIP Coding Roundtable sessions took place in conjunction with the MHIMA sponsored CPT seminars in Grand Rapids and Royal Oak. The format of these sessions was a true roundtable fashion in which seven topics were presented to the entire group. Three of these topics were CPT based questions received from members, and four were ICD-10 practice questions. The group was split into smaller sub-groups for discussion of the topics. After discussion, the sub-groups then reconvened into one large group to discuss the sub-groups' comments and come to one conclusion on each topic as a large group. Note, that these recommendations are not “official coding” advice, but the advice from coding peers, working on the front lines in our coding community. This was a great opportunity for participants to seek input from their peers on these topics, network with colleagues and meet new friends. The feedback received from participants was very favorable, and we will attempt to plan similar roundtable sessions in the future.

Terri McIntosh and Sheila Bowlds facilitated the groups. Thank you to the participants in the roundtable sessions for their excellent comments and participation!!!

We had a lot of consensus on the topic, but also a few varying answers too! The topics and group discussion/decisions were as follows:

Issue #1 - CPT Interventional Radiology

Issue: How would you code the following:

This is a case of a terminated myelogram. Access to the subarachnoid space was attempted with no cerebrospinal fluid. The patient was uncomfortable so the procedure was stopped. No sedation was given.

Would you code 62284-52 only? Note: this is a status indicator “N” and the hospital would receive no payment

OR

Code 62284-52 and code 72270-52 since the 72270 is the code that receives the APC reimbursement?

Group's Consensus:

All Groups:

Due to the fact that an attempt was made for injection the following was recommended:

62284- 52

72270-52

62284-53 for the MD/professional charge

Issue #2 - ICD-9 Coding Diagnosis: PEG Case #1

Issue: How would you code the following:



MHIMA

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Peggy Chapo, MS, RHIA, Editor
Marsha Allen, RHIA, Advertising

Deadline
for May/June issue:
April 15, 2010

**Please forward articles in hard copy
or electronically to the Editor.**

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CONTINUED FROM PAGE 1

Procedure: Upper GI endoscopy

Indications: Replace malfunctioning PEG

Procedure Description: After obtaining informed consent, the endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The GIF-160 Gastroscope was introduced through the mouth, and advanced to the second part of duodenum. The upper GI endoscope was accomplished without difficulty. The patient tolerated the procedure well.

Impression: - Mucosal changes consistent with long segment Barrett's esophagus

- Small hiatus hernia
- Old PEG removed with traction pull method. Replaced with 20 F BARD non-balloon replacement tube at 2.5 cm.
- Normal stomach
- Normal examined duodenum

Question:

Would you code 43246 or 43235 plus 43760? Is there any indications in the report that reflect that the PEG was performed after the endoscope was removed and NOT performed under endoscopic guidance?

Group's Consensus:

All Groups: ya
43235 plus 43760

Could query MD as to whether this was done with an EGD.
43246

Issue #3 - ICD-9 Coding Diagnosis: PEG Example 2

Issue: How would you code the following:

Procedure: Upper GI endoscopy/PEG

Indications: Place PEG because patient is unable to eat. Place PEG due to impaired swallowing.

After obtaining informed consent, the endoscope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously. The GIF-Q180 gastroscope was introduced through the mouth, and advanced to the third part of the duodenum. The upper GI endoscopy was accomplished without difficulty. The patient tolerated the procedure well. The total duration of the procedure was 15 minutes.

Findings: A small hiatus hernia was present. The entire examined stomach was normal. The patient was placed in the supine position for PEG placement. The stomach was insufflated to oppose gastric and abdominal walls. A site was located in the body of the stomach with excellent transillumination for placement. The abdominal wall was marked and prepped in a sterile manner. The area was anesthetized with 4 ML of 0.5% lidocaine. The trocar needle was introduced through the abdominal wall and into the stomach under direct endoscopic view. A snare was introduced through the endoscope and opened in the gastric lumen. The guide wire was passed through the trocar and into the open snare. The snare was closed around the guide wire. The endoscope and snare were removed, pulling the snare out through the mouth. A skin incision was made at the site of needle insertion. The externally removable 20 Fr Bard gastrostomy tube was lubricated. The g-tube was tied to the guidewire and pulled through the mouth and into the stomach. The trocar needle was removed, and the gastrostomy tube was pulled out from the stomach through the skin. The external bumper was attached to the gastrostomy tube, and the tube was cut to remove the guidewire. The final position of the gastrostomy tube was confirmed by skin marking noted to be 3.0 cm at the external bumper. The feeding tube was capped, and the tube site cleaned and dressed. The examined duodenum was normal.

Impression:

- Hiatus hernia
- Normal stomach
- Normal examined duodenum
- PEG placement



CONTINUED ON PAGE 3

March/April 2010

Question:

Would you code 43246 or 43235 plus 43760? Is there any indications in the report that reflect that the PEG was performed after the endoscope was removed and NOT performed under endoscopic guidance?

Group's Consensus:

All Groups:
43246 for direct placement

Issue #4 - ICD-9 CM Diagnosis: ICD- 10 Leg Cramps

Issue: What is the correct diagnosis code for **sleep related leg cramps**?

ICD-9-CM	ICD-10-CM
CODE(S) ASSIGNED	
327.52	G47.62
INDEX AND TABULAR VOLUMES	
ALPHABETIC INDEX: CRAMP(S), sleep related leg 327.52 TABULAR ORGANIC SLEEP DISORDERS (327) ORGANIC SLEEP RELATED MOVEMENT DISORDERS SLEEP RELATED CRAMPS	ALPHABETIC INDEX: CRAMP(S), sleep related G47.62 TABULAR EPISODIC AND PAROXYSMAL DISORDERS (640-G47) SLEEP DISORDERS (47) SLEEP RELATED MOVEMENT DISORDERS (G47.6) SLEEP RELATED LEG CRAMPS (47.62)
CODE(S) ASSIGNED	
<ul style="list-style-type: none"> • DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS (320-389) • DIAGNOSES CATEGORY: ORGANIC, SLEEP RELATED MOVEMENT DISORDERS, 327.52 	<ul style="list-style-type: none"> • EPISODIC AND PAROXYSMAL DISORDERS (G40-G47) • DIAGNOSES CATEGORY: SLEEP DISORDER (G47) • FOURTH DIGIT: SLEEP RELATED MOVEMENT DISORDER (G47.6) • FIFTH DIGIT: SLEEP RELATED LEG CRAMPS
CODE(S) ASSIGNED	
<ul style="list-style-type: none"> • TYPE OF CRAMP(S) 	<ul style="list-style-type: none"> • TYPE OF CRAMP(S)

This ICD-10 Checkpoint was submitted by Cheryl Saucier-Wilson (cssw2@yahoo.com), health information management student, Spokane Community College.

Source:
<https://cop.ahima.org/COP/Coding/News/ShowNewsItem.fusion?NewsID=7863>

Issue #5 - ICD-9-CM Diagnosis: ICD-10 Cleft Palate

This example is in the same format as example #4 and is available at: http://www.ahima.org/images/newsletters/code_write/2009/July/checkpoint.html

Issue #6 - Coding ICD-9 Diagnosis: ICD-10 Pathological Fracture

This example is in the same format as example #4 and is available at: http://www.ahima.org/images/newsletters/code_write/2009/May/checkpoint.html

Issue #7 - Coding ICD-9 Procedure: ICD-10 - Fracture

This example is in the same format as example #4 and is available at: http://www.ahima.org/images/newsletters/code_write/2009/August/checkpoint.html

NOW IS THE TIME TO VOTE

March 15, 2010 is the deadline for you to vote

Vote at www.mhima.org

The paper ballot was sent in the mail at the end of February. You will need to submit your ballot by March 15, 2010

Remember to include your Name and ID number on the paper ballot or it will not be counted. It must have a post mark no later than March 15, 2010.

Voting is your right and privilege. It is important for MHIMA that your vote is cast so it can be counted. Please be sure to vote!



RAC Corner

MHIMA is asking its membership to share current experiences with Recovery Audit Contractor (RAC) requests from CGI. You do not need to share what hospital you are from or how many letters you have received. We are looking primarily for the types of issues (i.e. Sepsis, Debridement, CHF) being looked at for complex reviews.

Please email Karen Cole at Karen.Cole@phns.com and share your current experiences with RAC requests. The results will be compiled and published.

Thank you.
Karen Cole, RHIT, CCS-P, CPC-H, RCC, CGCS



Electronic Care Connections The Future of Michigan

Wednesday, March 17, 2010

The American Room, Ramada Lansing Hotel & Conference Center
7501 W. Saginaw Highway, Lansing, MI 48917 517-627-3211

From East and West Take I-96 Exit at 93B Saginaw Highway. Hotel is one block on the right.

6 CE Credits – Technology AHIMA

This program includes:

TIME:

8:30 a.m. Registration
Seminar 9:00 AM 4:10 PM

COST:

\$110.00 members
\$125.00 nonmembers
\$35.00 student and one Educator per HIM Program.

Includes a continental breakfast, breaks, and lunch.

Registration Deadline: March 12, 2010

A \$15.00 processing fee will be maintained if cancellation is required. **Seminar must be paid for in Advance.** HIMSS and HFMA members will be accepted at the Active AHIMA member rate.

8:30-9:00 AM Registration – Continental Breakfast

9:00-10:00 AM **KEYNOTE ADDRESS:**

Janet Olszewski, Director, Michigan Department of Community Health

- The Michigan Health Information Network and what it means to Michigan

10:00-11:00 AM - **Denise Holmes, PhD, Associate Dean for Government Relations and Outreach and Director of Institute for Healthcare Studies, MSU College of Medicine**

- The Michigan Coalition for Health Information Technology
- The Michigan Center for Health IT Adoption

11:00-11:10 Break

11:10-12:10 - **Helen Hill, Director of IT Consulting and Health Information Exchange at Henry Ford Health System**

- Southeast Michigan Health Information Exchange (a Regional HIE)
- Beacon Communities Grant Proposal

12:10-1:00 PM Lunch Break

1:00-2:00 PM - **Steven Grant, MD, Chairman of the Board and Terrisca Des Jardins, MHSA, Vice President, my1HIE**

- my1HIE
- Physician Practice and Technology
- My Workspace Demonstration

2:00 3:00 PM - **Jim Lee, Vice President, Data Policy and Development, Michigan Health and Hospital Association**

- CMS Meaningful Use Proposed Rules and its Implications for Hospitals

3:00-3:10 PM Break

3:10-4:10 PM **Nancy Walker: Past President-Director, E-HIM Project Manager, MHIMA**

- MHIMA Initiatives and Implications for the Workforce

You may register and charge this seminar online at www.mhima.org under the Hot Topics section.

Checks payable to: MHIMA

Mail To: MHIMA Central Office, 3311 David-Bee Street, Muskegon, MI 49444-3619.

Contact: Marsha Allen at (231) 767-9717

Fax: (231) 767-2557

Name: _____ Email: _____

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Address: _____ City, State, Zip: _____

Check One: \$110 Member (includes HIMSS and HFMA members)

\$125 Non-member (includes CE only)

\$35 Student/educator (only one educator per program)

THE ANNUAL CONVENTION OF THE Michigan Health Information Management Association

will be held
May 12-14, 2010
at the
Detroit Marriott Hotel
Troy, Michigan

The Business Meeting will be on
Wednesday, May 12th at 10:15 a.m.

Bonnie Jameson, RHIT, CCS
Secretary/Treasurer

MHIMA
Michigan Health Information
Management Association



2010 Michigan Medical Record Charities Silent Auction

APRIL MARTIN, RHIA, CMT, AHDI-F, CHAIR SILENT AUCTION

Due to the success experienced with the past two years' Silent Auctions for Michigan Medical Record Charities, this event has become a regular event at the MHIMA Annual Meeting. The annual meeting this year will be held May 12-14, 2010, at the Detroit Marriott Hotel in Troy, Michigan.

Monies raised by Michigan Medical Record Charities are used to fund the student scholarships offered by MHIMA and to pay dues for the Yvonne Harbert Student Achievement Award winner.

Items up for bidding in this year's auction include:

- 2 rounds of golf by Double JJ Ranch
- family 4-pack of tickets by the Plymouth Whalers
- 2 children's tricycles by Continental Bike Shop
- 2 in-home wine-tasting parties by PRP International
- certificate for a 2009 webcast by AHIMA
- more photos by our own Margaret Neterer, RHIA
- broaches and collector dolls by Gaye Kendrick
- various gift baskets from members and groups
- and much more ...

Also in the Silent Auction booth will be MMRC glasses from last year's bowling event. These are high-quality 16-ounce pint glasses with MMRC on them which will be sold for \$5 each. The Marriott bar,

actually called the No-Name Bar, will be running drink specials to all attendees who have a glass on Thursday night. Be sure to purchase a glass and join us for some fun and networking in the No-Name Bar Thursday night.

Do you have a talent for creating great gift baskets? Would you be willing to create one for our 2010 Silent Auction? Do you have any items you would be willing to donate toward the 2010 Silent Auction? If so, please email April Martin at amartin@qidtranscription.com so she can arrange to obtain the items if you are unable to attend the annual meeting. Thank you for considering our request and for helping to support the next generation of HIM professionals.

and SAVE THE DATE ...

Second Annual Halloween Costume Party/Bowling Fundraiser
Saturday, October 23, 2010 at Ypsi-Arbor Lanes
Check-in at 7:30 p.m. - Bowling starts promptly at 8:00 p.m.

Watch for further details, but start putting your teams together now!

Be creative and informative!
 If you would like to contribute to an upcoming issue of **FOCUS**
 email the editor at pchapo@botsford.org





TREASURER'S REPORT
 FEBRUARY 10, 2010
 TOTAL MHIMA ASSETS
\$37,842.98

Sympathy

Deepest Sympathy to Karen Schmidt, RHIT, CCS, and her family in the loss of her mother-in-law, Margaret L. Schmidt, on February 1, 2010.

Sincere sympathy to the family of Joanie Koets, Past President of SWMHIMA on her death on February 21, 2010.

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Congratulations!

THE FOLLOWING MEMBERS HAVE PASSED EXAMINATIONS!

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 Sherry CreechNew Hudson
 Justine HouslanderLivonia
 Janet Holt.....Howell
 Tamara JacksonDetroit
 LuAnn LiningtonCrowell
 Tiffany Peterson.....Iron River
 Rebecca SierackiAlgonac
 Gerri VanBuskirk.....Port Huron

CCS's

Penny AdamsRedford
 Nancy MacDonaldCasco
 Janet Natzel.....Novi
 Laura PearsonAllen Park

CCS-P's

Ryan HornPortage
 Kitty MorseSaginaw
 Jeanette OberlinIron River

CHDA

Terri RathburnEagle

RHIA

Nicole OttobreBig Rapids

RHIT

Cynthia Bimberg.....Saint Clair Shores
 Brenda ClishClinton Township
 Stephanie Cornwell.....Michigan Center
 Donna Drew.....Flint
 Keith HarperShelby Township
 Jennifer HastyPentwater

Patricia Holden.....Warren
 Jessica KehoeAda
 Diane Krsul.....Windsor, ON
 Melissa LindseyLapeer
 Rosanna MccurryWarren
 Susan McDonaldGrass Lake
 Denine McKennaWarren
 Kent Nettleton.....Frankenmuth
 Constance RempalaSaint Clair Shores
 Marilyn RoggeDearborn
 Angela ScottLapeer
 Ronald StackCanadian Lakes
 Tamara Stallings.....Detroit
 Kelsie Stevens.....Stockbridge
 Deborah Thelen.....Jackson
 Wendy ThurkettleWyoming
 Amber Williams.....Burton

Working Smarter With Computer-Assisted Coding

Clinical Coding Community Sessions Explore Workflow Efficiencies And Quality Benefits

From AHIMA Today October 5, 2009

Today's code assignment and workflow processes can be inefficient, error prone, and costly. Presenters at the October 3, 2009, Clinical Coding Community Meeting described the latest in computer-assisted coding (CAC) and smart methods to encode health services for a variety of retrieval and reporting needs.

Despite some fears, CAC does not replace coders. In fact, the coder's role is critical in CAC, because the recommended codes must be validated.

Nancy Soso, MSHS, RHIA, from the University of Pittsburgh Medical Center, presented "Implementation of CAC at an Academic Medical Center." She described how CAC allows for improved accuracy, efficiency, and productivity. CAC also offers the potential to improve accuracy to support audit activities.

Speakers throughout the CAC sessions stressed that time savings are significant, offering these examples:

- Reduced number of systems requiring review (previously the hybrid record required the review of components in the EHR/scanned documents/paper record)
- Increased productivity and efficiency
- Increased accuracy

Adele Towers, MD, MPH, and Tamara Needham, RHIT, of University of Pittsburgh Medical Center, presented "Preparing Your Organization for Inpatient CAC." Needham explained that "eliminating dual screens due to various functions now allows all applications to run through the CAC application, thus streamlining the coding process."

The consistency that CAC offers also helps facilities normalize their coding, benefitting inexperienced coders.

Towers told attendees that the medical center realized the following improvements when implementing CAC in its hospital inpatient facilities:

- Increase in productivity by 20 percent
- Decrease in overtime by 85 percent
- Decrease in external auditor recommendation changes by 50 percent
- Decrease in external audit fees by 60 percent
- Increase in Medicare Case Mix Index (CMI) by 0.08 or 4 percent with same patient population

One of the most exciting aspects of CAC technology from an HIM perspective, according to Mark Morsch, MS, is how it can free up coders from mundane duties and allow them to focus on more challenging functions while improving productivity. Morsch, of A-Life Medical, presented "CAC with Standard Document Types Advancing Best Practice in Health Information Management."

CAC can also improve accuracy to help cope with all regulatory initiatives. The measurable benefits to management by computerized reports are significant.

Despite the benefits, CAC can be intimidating. "This is a major change, and it requires selection of technology," Morsch noted. However, he said, standards are being defined to help users make choices.

October 4th offered convention attendees a look at CAC firsthand. During the AHIMA Foundation Applied Health Services Research Corner, HIM professionals from the Seattle, Washington area demon-

strated how automation using natural language processing and CAC using electronic health records transforms and expands HIM practice.

Call for Papers: April 2010 Summit

Early in 2009, AHIMA convened a steering committee comprised of experts in linguistics, healthcare compliance, health informatics and information management, natural language processing, and technology. The group is guiding AHIMA efforts to raise awareness of innovation possibilities and create strategies to guide action.

AHIMA is planning the Computer Assisted Coding Summit for April 14, 2010, in conjunction with the annual ICD-10 summit in Washington DC.

Many CAC activities are planned for the wider community of practice focusing on standardization and innovation of the work process using technology tools. In addition to the 2010 summit, the steering committee is creating a road map to preferred future involving compliance-ready CAC systems that are widely accepted as useful and accurate.

White papers about CAC technology, the development of resources to evaluate CAC systems, creation of metrics, and fraud protection features and review functionality are just a few of the additional activities being considered. CAC represents a new future for coding working smarter and eliminating redundancy.

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President's Message

I couldn't have said it better...

As the cold winter months are behind us we look forward to *sunny*, warm months ahead in 2010. My message to you speaks of our profession - "**HIM's time to shine**"! Many of you may have read Rita Bowen's recent President's Message in the Journal of AHIMA, January, 2010.

I couldn't have said it any better than Rita. Rita states "Because as an association, as professionals, as the best and sometimes only vocal advocate for what we know is best for health information, we must be ready to *play*, to *lead*, to *win*."

In her message she continues by saying "If we don't (promote) quality and data integrity, who is going to do that? We have to quit sitting back. Having an EHR is about much, much more than getting rid of paper." She states "We have a once-in-a-lifetime opportunity to push the boundaries that currently divide us from the best of one another".

We can all agree with her statement "HIM is no longer a siloed department. Health information touches all points of an organization, and an HIM department should operate under this new premise by getting out and working directly with those people who create the information."

Rita also discusses mentoring one another indicating "We must assist our employers, our communities, and one another in moving health information management to the next level and the level above that."



**KAREN SCHMIDT, RHIT, CCS
PRESIDENT, MHIMA**

As we advance further in the sunny months of 2010 my wish is for us all to share Rita's momentum and enthusiasm in each of our HIM *shining* professional paths. *I couldn't have said it better.....*

Karen Schmidt, RHIT, CCS – MHIMA President

Managing Organization-Wide Content

Session Outlined the Principles of a Content Management Program

Perhaps no profession has embraced the idea of electronic health records more than HIM. The October 5, 2009 presentation at the AHIMA convention "Managing Electronic Information Beyond the Health Record" discussed the fundamental strengths and knowledge that HIM professionals bring to EHRs and encouraged attendees to apply those skills in developing and implementing larger content management programs.

A content management program encompasses more than just health records and includes records such as clinical records, research documents, contracts, and policies and procedures.

Sandra Nunn, MA, RHIA, CHP and Michele O'Connor, MPA, RHIA, FAHIMA, challenged participants to think beyond their traditional roles, describing what a content management program is and how collaboration with other departments is the key to successfully managing organization-wide content.

By collaborating with professionals in areas such as information technology, medical staff services, patient registration, and financial services, HIM professionals can create a quality content management program that addresses all aspects of the healthcare business.

By challenging attendees to think bigger and broader, Nunn and O'Connor set the stage for a fast-paced, innovative session that outlined new opportunities for HIM professionals.

Three types of Content

Fully understanding the concept of content management requires first considering the variety and amount of content available in healthcare today. Content can be divided into three areas; transactional content, business content, and persuasive content.

Transactional content is information that is usually comprised of scanned data, electronic forms, or faxed documents. Examples include claims or tax return forms for the organization. Business content is information that is related to office or messaging documents; for example, business plans and contracts. Finally, persuasive content includes items such as product catalogs and analytics. Examples of persuasive content include marketing materials and product photos.

Any or all of these content items could become a business record and fall under content management activities. Fundamental record management life cycle activities fall to HIM professionals, although they are typically narrowed to focus on only the health record itself. This session expanded that focus to include all aspect of a healthcare organization's business records.

Support Needed: Systems and Application Inventories

Following the discussion on basic content management components, attendees reviewed the need to develop systems and application inventories that support the information management lifecycle. Without strong life cycle management, content management efforts will not meet their full potential within the organization, said the presenters.

Nunn and O'Connor encouraged HIM professionals to lead their organizations in these efforts with their knowledge of the legal health record and designated record sets. By using the systems that support these two record sets, HIM professionals can transfer that knowledge into the beginning of a comprehensive system and application inventory. HIM professionals can become engaged in the development of these systems as their organizations move toward EHRs.

Some initiatives in healthcare today fully support content management principles. Initiatives such as business process management, electronic storage management, and legal and compliance efforts all support a fully functional content management program that HIM professionals can become involved in.

Document Management Requirements for Nontraditional Data

Finally, Nunn and O'Connor challenged attendees to think beyond the EHR and identify document management requirements for other types of nontraditional data such as e-mail.

In the current environment e-mail is captured content that often reflects provider-patient exchanges. In some instances e-mail may be integrated content and an index point in the EHR.

In the future, e-mail will be captured via metadata and migrated into the EHR. In addition, content management applications allow for easy search and retrieval of the information for e-discovery and legal matters.

The use of e-mail has evolved into a standard of care practice within the healthcare community, and HIM professionals are managing this nontraditional information as a clear and concise portion of the patient's health record.

The session ended by identifying new opportunities for HIM professionals in content management programs and the skills and knowledge those roles require. HIM professionals can explore new prospects in their career path by applying their time-trusted foundational records management principles to the larger scope of content management.

FROM AHIMA TODAY, OCTOBER 6, 2009

New Members MHIMA February 2010

Usama Abdulrehman.....Troy	Saturnina GrantDetroit	Lisa PlazaSouthgate
Winifred Ackron-Daoust.....Taylor	Nikkia GreenDetroit	Newoka Pollock.....Harper Woods
Cheryl Adams.....Roseville	Katherine GreeningGrand Rapids	Tina Ponke.....Center Line
Keli AdisWestland	Leah GrusnisGrand Rapids	Cynthia Post.....Grand Rapids
Velyendia AlexanderhoodFlint	Andre GulledegeDetroit	Nicole Prabel.....Saint Clair Shores
Meredith Alfred.....Rockwood	Jennifer HalbrooksClinton Township	Susan QueentryClinton Township
Joel Allen.....Mount Pleasant	Larry HamiltonOxford	Giuseppa Randazzo.....Taylor
Kathy AntleTaylor	Mary HarrGrosse Pointe Woods	Rebecca RanneyOtisville
Nancy ArvaiBeverly Hills	Jamie Harris.....Macomb	Lakisha ReidSterling Heights
Joann AskinRoseville	Mary Beth Harrison.....Royal Oak	Jenee Renaud.....Monroe
Laura Barth.....Onsted	Diane HarvellLansing	Jennifer Richardson.....Saginaw
Rachel BaumannMacomb	Wail HassanDearborn	Jerry RobertWarren
Melissa Bedard.....Roseville	Rema Hazime.....Dearborn Heights	Jennifer Roberts.....Carsonville
Antoinette Bell.....Chesterfield	Toby Hebron.....Cassopolis	Greg Robinson.....Chesterfield Township
Stephanie BockGladwin	Shari Hein.....Grass Lake	Thomas Rodgers.....Sterling Heights
Lisa Bolda.....Clinton Township	Kristin Hellebuyck.....Shelby Township	Heather Rombach.....New Lothrop
Christine BontragerDavison	Kellie Hillis.....Washington	Dena Roose.....Shelby Township
Sharon BrenzWarren	Kellie HineMount Pleasant	Angela Rosema.....Grand Rapids
Anne BrownEaton Rapids	Janet HoltHowell	H. RosenthalNiles
James BrownBig Rapids	Darendra HowardGrand Rapids	Amy RowlisonJackson
Sheree Brown.....Detroit	Kimberly HuberMount Pleasant	Deborah SackerCasco
Diane Browne.....Dearborn	Kristine Huberts.....Alto	Myeshia Sampson.....Detroit
Brian BudzynMacomb	Susan HungerfordMadison Heights	Patrick SaroliMacomb
Christine BurkGrosse Pointe Woods	Treinerne Hunter.....Detroit	Hillary SchockeDavison
Marcina Butcher-DunnMelvindale	Tameka HusseyTaylor	Janessa SchroederGrand Rapids
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Ashley Cathey.....Kalamazoo	Jennifer JunkinMacomb	Heidi SeitzingerBay City
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Marcia CoasterRoseville	Nikole KovalakCassopolis	Cheryl SimpkinsLake Linden
Melissa CollinsClinton Township	Glynda Krantz.....Troy	Patricia Smith.....Holly
Shayna ComiskaSaint Clair Shores	Deanna LaRoseGaylord	Penny Smith.....Niles
Karie CrispMelvindale	Jessica LatowskiHarrison	Tachikie Smith.....Southfield
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Susanne GleasonRoyal Oak	Stephanie Picard-GardnerMuskegon	



HIM Domains

HIM Professional Domain Definition: HIIM improves the quality of healthcare by ensuring the most timely and accurate information is available to make any healthcare decision. HIIM professionals manage healthcare data and information resources. The profession encompasses services in planning, collecting, aggregating, analyzing, and disseminating individual patient and aggregate clinical data. It serves the following healthcare stakeholders: patients, providers, patient care organizations, research and policy agencies, payers, and other healthcare-related entities.

Eighty percent of all CEUs must be earned within the HIIM Domain, which is divided into the domain areas below.

The CCHIIM provides the following list of examples of educational experiences. These educational experiences may include but are not limited to the following:

1. **Technology:** Application of existing and emerging technologies for the collection of clinical data, the transformation of clinical data to useful health information, and the communication and protection of information on analog medium, (for example, paper, analog photographic film, and so on) or digital medium, (for example, magnetic tape, optical disk, CD, DVD, and so on). Topics include but are not limited to: Electronic health records (EHRs)
 - HIIM software applications (encoders, patient information management systems, chart management, and so on)
 - Personal health record (PHR)
 - Health information exchange (HIE)
 - Speech recognition
2. **Management Development:** Application of organizational management theory and practices in addition to human resource management techniques to improve departmental adaptability, innovation, service quality, and operational efficiency. Topics include but are not limited to:
 - Project management
 - Training and development
 - Work design
 - Employee hiring and retention AHIMA Recertification Guide 10
3. **Clinical Data Management:** Applications and analysis of quality and clinical resources appropriate to the clinical setting to include database management, and coding compliance using CPT, ICD-9-CM or other specialized coding systems within the prospective or payment system to ensure quality and cost effectiveness of the services rendered; i.e., data integrity, quality of documentation, clinical efficiency. Topics include but are not limited to:
 - ICD-9-CM/CPT/HCPCS
 - Prospective payment systems (DRG, APC, etc.)
 - ICD-10
 - Registries
4. **Performance Improvement:** Development and application of quality processes to ensure quality data is generating consistent, timely quality information; to develop systems that are flexible and adaptable in a constantly changing healthcare environment (for example, e-HIM, regulatory changes, new technology.) Topics include but are not limited to:
 - Outcomes data management
 - Revenue cycle management
 - Clinical practice guidelines
 - Remote coding or computer-assisted coding
5. **External Forces:** Study of regulatory requirements and the development of appropriate compliance initiatives for policies, procedures, protocols, and technology for hospitals, specialty facilities, and other healthcare providers to include the development of systems (for example, e-HIM) and to implement required practices for the Joint Commission and other accrediting bodies, federal and state appropriate rules and regulations; (i.e., Centers for Medicare and Medicaid Services, HIPAA. Topics include but are not limited to:
 - OIG work plan
 - HIPAA
 - Compliance
 - Legal or regulatory update
 - CCHIT accreditation
6. **Clinical Foundations:** Understanding of human anatomy and physiology, the nature of disease processes, the protocols of diagnosis and treatment of the major diseases to include common drugs, and laboratory and other tests used for the diagnosis and treatment of disease. Practice the ability to apply this knowledge to the reading, coding and abstracting of medical information to support quality patient care and associated databases. Topics include but are not limited to:
 - Pathophysiology
 - Pharmacology
 - Clinical intervention
 - Diagnostic and laboratory testing
 - Telemedicine AHIMA Recertification Guide 11
7. **Privacy and Security:** Understanding and application of current healthcare regulations that promote protection of medical information and the electronic transmission of health information; to act as the patient's advocate for their understanding of their rights in regard to protected health information on any applicable analog or digital medium. Topics include but are not limited to:
 - Release of information
 - Confidentiality
 - Personal health information
 - Security risk assessment
 - Security audit
 - Privacy risk assessment





ATTENTION MHIMA MEMBERS

We Need You!

Are you interested in serving MHIMA on a Committee or Project? The following Projects are part of MHIMA and can use the help of qualified professionals.

EDUCATION: Help schedule and set up educational meetings for the year.

ANNUAL CONVENTION/AWARDS/PROMOTIONS: Help with arrangements and the program for the annual meeting, or help with selecting Yvonne Harbert Student and/or MHIMA Distinguished Members or select items for promotions to be sold throughout the year.

CDIP CODED DATA INTEGRITY POLICY: Send your resume to help this group to assist in scheduling Coding Roundtables that are pertinent to your needs and answer coding questions from MHIMA members.

You must have a minimum of five years of coding experience.

COMMUNICATION: FOCUS Help write articles and edit the newsletter.

COMMUNITY EDUCATION CAMPAIGN: Train other trainers to present My PHR throughout the community, or become a trainer to bring My PHR to your local community.

MHIMA COMMUNICATION RESOURCES: Help create and implement policy, procedures and methods for keeping members informed quickly regarding important legislation and other pertinent issues.

MONITOR LEGISLATION: Help MHIMA keep abreast of current healthcare legislation that will affect our members.

Yes! I am willing to participate in MHIMA's future!

I would be willing to serve (project/committee): _____

Place Of Employment: _____

Name (Typed/Printed): _____ Signature: X _____

Phone: _____ Date: _____ Email: _____

You may also submit names of any MHIMA active or associate members who would be qualified for office or committee membership:

Name: _____ Phone: _____ Email: _____

Name: _____ Phone: _____ Email: _____

Name: _____ Phone: _____ Email: _____

Please return this completed form by March 31, 2010 to:

Chris McCann MPA, RHIA
c/o MHIMA Central Office
3311 David-Bee Street
Muskegon, MI 49444
Phone: 231-767-9717
Fax 231-767-2557





An ROI on ROI

Speakers Describe a Release of Information Shared Services Model That Splits

All facilities require a dedicated release of information (ROI) function, and they have traditionally either performed it in-house or wholly outsourced the function. Performing ROI in-house is often fraught with difficulties, such as slow turn-around times and service limitations with fulfillment and invoicing. These challenges result in high labor costs and continued struggles to meet external requestors' expectations. The other alternative, a fully out-sourced model, often results in lack of control and transparency as well as loss of any potential revenue the facility might receive from ROI fees.

A third model is available, though, a hybrid of these two extremes: the shared services model. At the October 5, 2009 educational session at the AHIMA Annual meeting, "Leveraging EMRs for Revenue Positive Business Processes: Release of Information Management at Lehigh Valley Hospital" Zelda Greene, MS, RHIT, of Lehigh Valley Health Network and a representative from a release of information company shared their success with implementing the shared services model at Lehigh Valley Health Network.

A New Model for ROI

Health information management at LVHN is consolidated and organized by function. The operations area serves the ROI needs for three acute care hospitals and the hospital-based clinics. For nearly 20 years release of information was handled through a fully outsourced ROI vendor. Under this model, LVHN provided the equipment and space in its facilities, while the ROI vendor handled everything related to the ROI function and kept all fees.

This model seemed to work, with turn-around time on requests averaging 7-14 days. But service complaints were common, and LVHN had little ability to manage its compliance risk. With growing regulatory complexity this was becoming an increasing problem. In addition, as LVHN transitioned more fully to an EHR it seemed more realistic to centralize the ROI function. Lastly, there was increasing pressure to identify new revenue opportunities.

So LVHN embarked on a journey to bring release of information back in house. But their goal was to do this without increasing operational costs. They chose the shared services model.

Under shared services, the healthcare organization performs "front-end" functions while the vendor assumes responsibility for "back-office" processes. This requires that the healthcare entity and the ROI vendor establish a precise division of labor. According to Greene, "The shared services model was a good process for us [LVHN] because we did not want to become involved in billing for ROI. We were adamant about that".

Work and Revenue

LVHN's ROI Process

LVHN's ROI staff receives and validates requests for information, handling approximately 30,000 non-billable and 16,000 billable requests annually. LVHN is responsible for logging the requests, confirming their validity, identifying the medical records, and checking those records for completion. Once this is done, they make the appropriate encounters available to the shared services vendor.

The vendor is then responsible for electronically and remotely performing the medical record or document selection, releasing the selected information to the requestor, and submitting a transaction summary electronically to LVHN. The vendor also provides full customer service including invoicing as well as all communication and interaction on the status of the request. No paper is involved for most requests.

The shared services ROI process is more efficient, Greene said. LVHN dedicates only three HIM staff members to release of information, one of these specifically to RAC requests. Previously the outsourced vendor required five people on-site. In addition, turn-around time has improved from 7-14 days to 5-7 days, and service complaints have declined dramatically. LVHN also has more detailed reporting available on ROI volumes and the status of individual requests.

LVHN met its operational goal. Green told session attendees, "We receive a revenue check every month, which I am very happy to have, and we are now considered a revenue producing department in our organization."

So while LVHN had not viewed ROI as an important source of income, they are now generating a modest income, enough that the implementation was virtually cost-neutral.

Greene encouraged session attendees to "look for nontraditional approaches to solving medical record issues." As LVHN has transitioned to an EHR over the last 10 years, it has consistently reduced staff. But instead of simply eliminating people, the organization has looked for new responsibility they could take on to create new jobs. This move to the shared services model gave Greene an opportunity to shift staff to the ROI process who might otherwise have been eliminated.

Good employees are retained, Greene has more control over ROI, and HIM is producing revenue a good return on investment from any angle.

FROM AHIMA TODAY, OCTOBER 6, 2009

E-HIM Project Update February 2010

NANCY WALKER, MS, RHIA

The MHIMA is represented on a number of groups that have received federal ARRA monies to achieve meaningful use for healthcare in Michigan. We also have representation on groups that are waiting to hear if funding is approved.

The graphic below shows how ARRA provides incentives to both hospitals and providers, and has created funding opportunities so that in Michigan we can pursue those HITECH opportunities.

The state was awarded a grant for the creation of a backbone to link all the regional HIEs together. Nancy Walker has been elected to sit on the Measurement subcommittee of the Governance group. Moira Davenport-Ash has been elected to sit on the Privacy and Security Subcommittee of the Business Operations Workgroup along with Nancy Walker. Elected positions mean we are voting members on those groups and have a say in the outcome and design of the backbone. The state backbone will link all the regional HIE's together, such as the

operational Capital Area RHIO and the Southeastern Michigan Health Information Exchange. The state is also working on the Medicaid portion of the incentive program from ARRA and that means they are coordinating their work with the state backbone initiative.

The M-CEITA is the Michigan Center for Effective IT Adoption. They were funded to create a regional extension center to assist the primary care physicians in their transition to meaningful use of technology for healthcare. Nancy Walker sits on the Steering Committee. Altarum Institute is the named grantee and will be providing jobs for those interested in assisting the physician practices and clinics in their region toward meaningful use of technology.

MCHIT is the Michigan Coalition of Health Information Technology. Initiatives have included workforce development and a test lab for all types of technologies, both for the user and for researchers.

SEE ACCOMPANYING CHARTS ON PAGE 13.

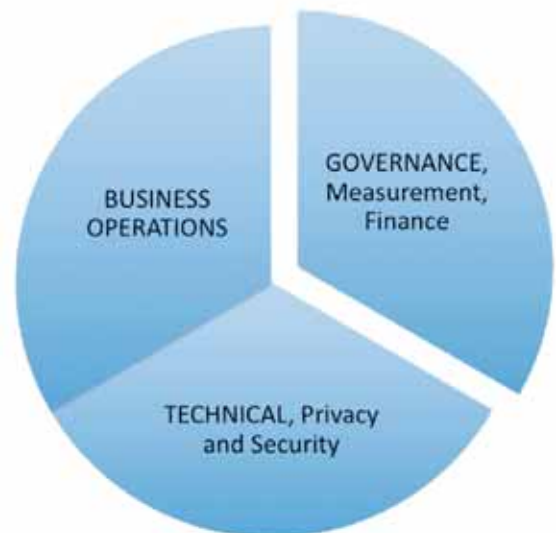


American Recovery and Reinvestment Act 2009



M-CEITA

MiHIN Workgroups for State Health Exchange Cooperative Agreement Program



Membership Report - February 8, 2010

SUBMITTED MARSHA A. ALLEN, RHIA

CLASSIFICATION	MEMBERSHIP AS OF DECEMBER 10, 2009	MEMBERSHIP AS OF FEBRUARY 8, 2010	CHANGE
Active RHIT/RHIA/CCS/CCS-P/CCA/CSP	1802	1835	+33
Active Senior	45	46	+1
Student	688	815	+127
Graduate	114	128	+14
Honorary	2	2	-
Corporate	13	9	-4
	2664	2835	+171
Certified Non-members	948	952	+4

Corporate Members 2010

7/93	VanBelkum Companies 4345 44th Street SE, Suite C Grand Rapids, Michigan 49512	Greg Ingersoll Director, Sales & Marketing (616) 974-8200	www.vanbelkum.com
3/94	The Rybar Group, Inc. 3150 Owen Road Fenton, Michigan 48430	Claudine Hildreth Marketing Operations Director (810) 750-6822	www.TheRybarGroup.com
10/96	Nuance Healthcare One Wayside Road Burlington, Massachusetts 01803	Lauren Underhill Marketing (781) 565-5000	www.nuance.com
8/98	Dolbey and Company 7418 Gateway Park Drive Clarkston, Michigan 48346	Mark Kuenzel Regional Vice President (888) 384-7828, Ext.155	www.dolbey.com
3/03	TLM Consulting P.O. Box 456 St. Clair, Michigan 48079	Terri McIntosh (586) 216-8108	www.tlmcintosh@comcast.net
2/05	CareTech Solutions, Inc. 901 Wilshire Drive, Suite 100 Troy, Michigan 48084	Leslie Mack Senior Director iDoc Document Imaging Delivery Division (877) 700-8824	www.caretechsolutions.com
3/06	United Transcription 5000 Nations Crossing, Suite 201 Charlotte, North Carolina 28217	Keirsten Huth Vice President (704) 527-8244	www.unitedtr.com
1/08	MRO Corporation 1016 W. 8th Avenue, Suite A King of Prussia, Pennsylvania 19406	John Walton V.P. Sales & Marketing (610) 994-7500	www.mrocorp.com
4/09	Iron Mountain 7277 N. Haggerty Canton, Michigan 48187	Ana Garcia Manager Healthcare Accounts (734) 456-5000	www.ironmountain.com
4/09	Davenport University 643 S. Waverly Road Holland, Michigan 49423	Susan Slajus Associate Dean Health Professionals (616) 395-4668	www.davenport.edu
2/10	SOAP Transcription Services, Inc. P.O. Box 373 Wayland, Michigan 49348	Dan Curran Sales Manager (269) 792-6363, Ext. 107	www.soaptranscription.com

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Management Association

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Muskegon, MI 49444



POSTMASTER, DATED MATERIAL, PLEASE DELIVER PROMPTLY!

MICHIGAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

Calendar Of Events

DATE	SPONSOR	LOCATION	TOPIC	CONTACT	PHONE
March 17, 2010	MHIMA	Ramada Inn. Lansing	Electronic Care Connections	MHIMA	231-767-9717
March 19, 2010	MHIMA	MHA Lansing	Board Meeting	MHIMA	231-767-9717
March 22, 2010	AHIMA	Washington, DC	Winter Team Talks	AHIMA	www.ahima.org
March 23, 2010	MHIMA	Washington, DC	Capitol Hill Day	AHIMA	www.ahima.org
May 7, 2010	MHIMA	Conference Call	Board Meeting	MHIMA	231-767-9717
May 12-14, 2010	MHIMA	Marriott, Troy	Annual Meeting And Exhibits	MHIMA	231-767-9717
July 16, 2010	AHIMA	Chicago, Illinois	Summer Team Talks	AHIMA	www.ahima.org
July 17-18, 2010	AHIMA	Chicago, Illinois	Leadership Conference	AHIMA	www.ahima.org
July 23, 2010	MHIMA	MHA, Lansing	Leadership Conference And Board Meeting	MHIMA	231-767-9717
September 19, 2010	MHIMA	Conference Call	Board Meeting	MHIMA	231-767-9717
September 25-30, 2010	AHIMA	Orlando, FL	Annual Meeting And Exhibits	AHIMA	www.ahima.org
November 19, 2010	MHIMA	MHA Lansing	Board Meeting	MHIMA	231-767-9717
January 21, 2011	MHIMA	Conference Call	Board Meeting	MHIMA	231-767-9717
March 18, 2011	MHIMA	MHA Lansing	Board Meeting	MHIMA	231-767-9717
May 6, 2011	MHIMA	Conference Call	Board Meeting	MHIMA	231-767-9717
May 11-13, 2011	MHIMA	Soaring Eagle, Mt. Pleasant	Annual Meeting And Exhibits	MHIMA	231-767-9717
May 16-18, 2012	MHIMA	Lexington, Lansing, MI	Annual Meeting And Exhibits	MHIMA	231-767-9717
May 15-17 2013	MHIMA	Grand Traverse Resort, Traverse City, MI	Annual Meeting And Exhibits	MHIMA	231-767-9717