Summer 2021

Lompoc Healthcare District Medical Staff Newsletter

LOMPOC VALLEY MEDICAL CENTER
Lompoc Healthcare District

In this Issue

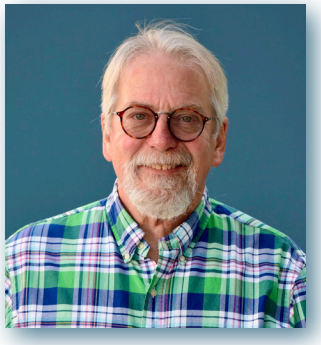
VACCINES

Vaccination of Lompoc is proceeding apace. Many of us have seen the lines of people awaiting their shots and it is a welcome sight indeed. To date, we have given a total 21,362 doses of the vaccine including all three manufacturers. About 75 percent of the LVMC staff overall have been vaccinated at the hospital and other sites. Pfizer has authorized its vaccine to be used in everyone aged 12 and older while Moderna and Johnson and Johnson may be used in ages 18 and older. Since April 17, LVMC has given 86 doses to 12-year-olds and 1,078 doses to people ages 13 to 17.

There have been reports of myocarditis and full body inflammation after vaccination in the young patients, but every source I looked at concluded that the risk was small and that, in almost every case, recovery was complete. Interestingly, this same problem was seen after a strong push to vaccinate against smallpox in 2003. In that event, a total of 7 people of the 25,645 vaccinated developed myocarditis.

Data on the process for obtaining full FDA approval for the various vaccines is scant and hard to come by. I believe that Pfizer requested an expedited review from the FDA in May 2021, which could cut the time to approval from the usual 10 months to 6 months. I do not have any type of solid confirmation on these facts. I am hopeful that once the vaccines are taken off the Emergency Usage classification and given full approval, many more people will feel it is safe to get vaccinated.

I see things returning to normal, for instance, Home Depot has dropped its mask mandate for customers. I am grateful for these signs of normalcy and look forward to ongoing improvement.



William J. Pierce, MD
Chief of Staff

See more from the Chief of Staff on page 3

REMINDER

Regular Medical Staff Business Meetings & CMEs

Tuesday, July 27 - Tuesday, August 31 - Tuesday, September 28

7am - Ocean's Seven Cafe

CMO Perspective

Randall Michel, MD, FACS
Chief Medical Officer

Summer is now officially here, and California is starting to open up. With many more people now fully vaccinated, things are starting to look a lot more normal. We continue to get new updates from the California Department of Public Health regarding mask wearing in the hospital for staff, visitors, and patients. Melissa DeBacker and her staff in Quality Assurance are providing stickers for badges indicating that someone has been fully vaccinated against COVID-19.

It seems like so much has changed in just over a year.

I wanted to take a little time to consider Dr. Bill Pierce's newsletter column this past spring regarding the fine care provided by our nurses and staff during the COVID epidemic. I know that we of the medical staff have all observed the fine work that our hospital staff puts into caring for our patients. I recently have had an experience to be on the other side of the doctor patient and hospital staff relationship. I think sometimes, as we practice medicine, we forget how much of a difference it makes in the way we talk with our patients. I have long felt that nurses have always had this figured out. Words of compassion, encouragement and empathy are some of our best therapeutics. A person with a serious illness, knowing that they have the support of an empathetic care team, can make all the difference in the world. I have always been proud to say that I am on the medical staff at Lompoc Valley Medical Center and my recent experience with our diagnostic imaging, laboratory, anesthesia, surgery, cardiopulmonary and pathology services reinforces my pride in the services we provide.

I hope that everyone has a good summer and has a chance to travel to see friends and family.

Steve Popkin
Chief Executive Officer

CEO Thoughts

Greetings, Medical Staff Members,

Our fiscal year is coming to an end on June 30. Thankfully, even with the financial hardships of Covid, we will end the year in a solid financial position, and better than the prior year. For the upcoming fiscal year, beginning July 1, we have a much more robust capital budget than is typical for LVMC, and more robust than is typical for hospital-based systems of similar size.

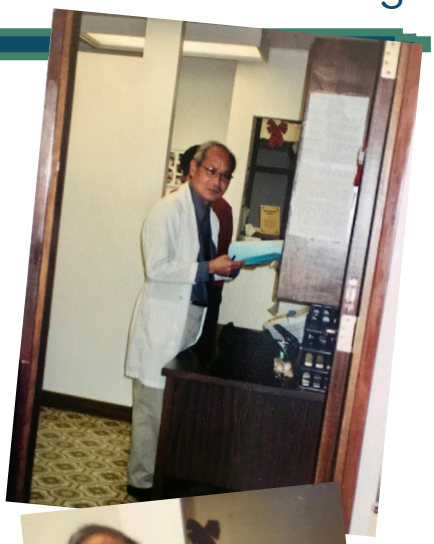
We will be "spreading the wealth" through many areas of the hospital, CCC, and Lompoc Health, but will be making very significant investments in the areas of Diagnostic Imaging and Surgery. In addition, although we will be continuing with our current information system provider (Allscripts—except for Lompoc Health), we will be implementing an upgraded version that will make LVMC's work much more efficient and productive.

LVMC's goals for the upcoming fiscal year are many, but two of them are to enhance our clinical capabilities from a technological perspective so that Lompoc residents can stay local and still receive state-of-the-art diagnostic and medical care, and to fine tune our processes throughout LVMC to optimize the patient experience and eliminate patient dissatisfiers.

I greatly appreciate the strong partnership that exists between LVMC and its Medical Staff, and I look forward to a very bright future moving forward together.

END OF AN ERA

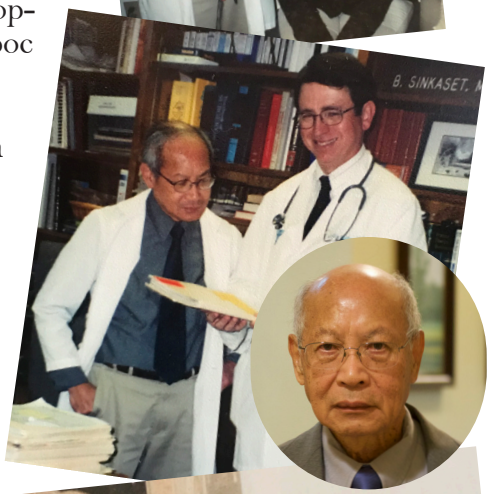
By William J. Pierce, MD; Chief of Staff



As I write this, I am trying to wrap up plans for a retirement party. We are preparing to celebrate a life dedicated to the greater Lompoc community and whatever we plan seems so inadequate, so understated.

I am, of course, referring to the retirement of Dr. Bandhit Sinkaset, who I have had the privilege of knowing and working with for the past 14 years.

Educated in Thailand and trained in Surgery in the United States, primarily in California, he came to Lompoc in 1979 (42 years ago) and has been working here ever since. He is expert in abdominal, chest and vascular surgery, and even some GYN surgery. Up until a few years ago he was still doing carotid endarterectomies, an operation we did together many times. He has seen many changes in Lompoc and has worked with some storied physicians over the decades like Drs. Elam, Sawyer, Gausman, Bailey, Andersen and Michel to name but a few. He saw the closure of the old hospital and construction of the new one a decade or so ago with its new, modern equipment and facilities.



One thing has remained constant, though. No matter what the complexities, difficulties, or hours spent on a case, he has never, ever given up or performed anything less than his best possible surgery. This includes many instances of extremely daunting conditions which I have witnessed personally. Small in stature, he possesses a force of will the likes of which I have not seen in anyone else. He keeps everyone he operates with motivated to be as excellent as they can be. He quietly moves tissue to gain the best exposure, never abruptly or roughly which, of course, is enormously helpful. There is scarcely a family in Lompoc which has not had at least one member undergo surgery by his hand. Many times, the question is asked: "Is Dr. Sinkaset available?" even when he is not on call. That is somewhat humbling to the rest of us, but entirely well earned and deserved. If one or the other of us is getting pounded on call, he will offer to do the latest appendectomy or cholecystectomy for us to give us a break, and he actually means it. He is the quintessential great partner -- never mean-spirited and always ready to lend a hand or make a suggestion based on decades of hard experience. We all feel the impending loss of our partner, our surgeon, our colleague, our mentor. We have been busy trying to keep him active, but have not yet succeeded in doing so. As with all of us, the future is unknown, but he is welcome to remain engaged at whatever level he chooses.

HIM Hints

by Barbara Frink
Director Health Information Management
Privacy Officer

Medical Necessity:
Getting the Third-Party Payers to Pay

There are two calls that a coder receives that will cause him/her to immediately cringe. One call comes from a patient stating that their insurance company says that if the account was coded with code XXXXX, the insurance company would have paid the for the services. The other call comes from the billing department. The biller submitted a claim and received a denial from the third-party payor because the codes submitted do not meet medical necessity and will not be reimbursed. For the patient call, the patient wants the codes changed to match what the insurance company told him/her would be paid at 100 percent. The biller wants to know if the coding can be changed to meet medical necessity. The coder has to tell both the patient and the biller that the codes can't be changed because the physician documentation doesn't support adding the codes needed in either situation to receive payment. The patient caller will have to pay the full amount of the bill, because documentation does not support the code that the payer wants. The account the biller called on will result in no payment to the facility or the physician in most cases or will result in the patient being 100 percent liable for the bill if an advance beneficiary notice was signed. How can this be avoided?

In this article I am going to briefly explore Medical Necessity. For a long time, Medical Necessity has been a determining factor in Medicare's willingness to pay for a member's medical care. The basic definition that all payers use for their own definition are usually derived or based on the Medicare definition of Medical Necessity. The other payers do not have to use the same criteria, however. What the other payers use is defined in their standards, usually found in contracts or on the insurance website. Medicare defines medical necessity as: "Services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Sounds like they should cover most medical care, doesn't it? The caveat is that the Social Security Act gives Medicare the power to determine this on a case-by-case basis. Medicare has written "rules" for meeting medical necessity. These are called LCDs or NCDs (Local Coverage Determinations or National Coverage Determinations). LCDs and NCDs are being switched to articles and can be found on the CMS website. Not all are converted yet, so a procedure or test may still be found as an LCD or NCD.

The articles/LCDs/NCDs describe the requirements that must be met in order for the service to be covered by Medicare. They may require certain tests be completed prior to a more involved test or surgery. There is almost always a list of the ICD-10-CM codes that they will cover for the service. If that code is not on the claim, the claim will be denied. This process is the same for all payers. What might vary are the rules or standards each payer requires. So how can you, the physician/healthcare provider make sure that you get paid and the facility gets paid, without putting much of the financial burden on the patient?

Physician/allied healthcare provider documentation in the patient chart is what determines which ICD-10 code can be applied. If the physician is not specific and detailed in the documentation that is entered in the chart, the coder cannot apply the specific codes needed to meet medical necessity. All documentation must be in the chart prior to billing the account to be considered in the determination for medical necessity and,

Continued on page 5

Continued from page 4

therefore, payment. You can add information after the account is billed, but Medicare especially will not consider it if added after the account is billed. What they will allow is for the coder to query the physician for more specific documentation prior to coding and billing the account. As I have written previously, there are very strict rules for querying, most importantly, the coder cannot lead the physician to the specific information they need that would result in payment for the service. Since in both examples at the beginning of this article, the accounts have already been submitted for payment, no new documentation will be considered by the payer. Since the existing documentation does not support more specific or different coding, the coder is not able to change anything in either account that would benefit the patient or the biller.

An excellent article I found when doing research for this article is one from Dr. Erica Remer, who wrote an article for the online ICD10monitor. It is called "Excellent Documentation is Necessary to Meet Medical Necessity." I highly recommend taking a few minutes to read the article. One paragraph from that article says: "If medical necessity does not seem to be supported by the documentation, one of two things has occurred: the service was not medically necessary, or the healthcare provider did not give enough clinical support (documentation) for the reviewer to recognize the medical necessity. I am going to state now for the record that it is preferable to invest a few sentences up front to support a medically necessary admission or treatment rather than to expose oneself to the time drain that is denial appeals." As Dr. Remer states, a claim can be appealed but this is a time-consuming process and may still result in a denial if the documentation needed is not in the account. If the physician or facility has received payment on the account, the amount must be refunded, plus a payment for interest on the amount paid back.

What happens if codes are added without supporting documentation? Diagnosis and procedure codes assigned to an account absolutely must be supported by documentation that is very specific. Coders cannot assume anything and must follow all Official Coding Guidelines. Multiple instances of adding unsupported codes by a physician/allied healthcare provider or a facility will result in charges of insurance fraud and abuse. Since the start of this year, I have seen charges and settlements filed against physicians and/or facilities on a rate of about one a week. Insurance or Medicare auditors will ask for records for 100 patients over a time span (most often 2 years). If they find, for example, that 40 percent of the claims had one or more errors, they will not only ask for the money to be returned (plus interest) on those 40 claims, but they will also estimate that 40 percent of ALL of the claims they paid out over those two years must be refunded (plus interest). For Medicare, this can result in being put on the Medicare Exclusion List, followed by other payers doing the same.

Whether medical necessity is met is totally controlled by the third-party payers. Unfortunately, they do not go by our rules and thoughts on the subject. As the saying goes: "The best defense is a good offense." When you are talking about insurance companies and Medicare, that means excellent documentation, with specific descriptions and diagnoses that comply with their documentation requirements. No physician, allied healthcare provider nor medical record department can change the rules set by those that we depend on to help pay for a claim. The best we can do is ensure that documentation is specific and precise, that copy and paste is not used as a way to fluff up the documentation, and make sure that all codes added to a claim (both diagnoses and procedure codes) are truly supported in the documentation prior to billing.

For more information, or if you have any questions, please contact
Christy Moegelin, Coder
moegelinc@lompocvmc.com

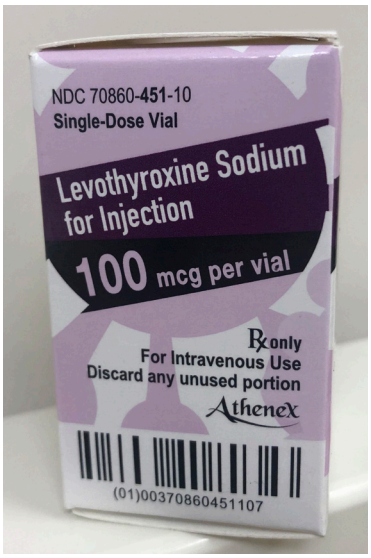
Here is the website address for the article discussed above:
https://www.icd10monitor.com/excellent-documentation-is-necessary-to-meet-medical-necessity

The Pharmacy Corner

DID YOU KNOW?

Did you know there are pre-built order sets to assist in ordering for common conditions such as hyperkalemia, anticoagulation reversal, and snake bites? These sets have all formulary relevant medications with dosages as well as labs and imaging if appropriate.

Did you know that IV levothyroxine has inconsistent supply issues and is 100x more expensive than oral levothyroxine? But due to the pharmacokinetic properties of levothyroxine, we can delay the need for continuing levothyroxine in NPO patients who are routinely taking their home dose for up to 5 days -- preserving this medication for those that critically need the IV form.

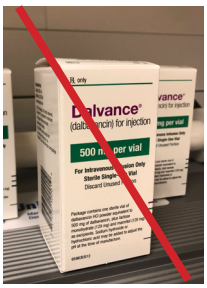


UPDATES TO THE FORMULARY

Additions:

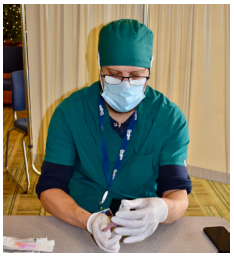
Agatroban has been added to the formulary for the prophylaxis or treatment of thrombocytopenia in adults with heparin-induced thrombocytopenia (HIT). In addition, a HIT Management Protocol was approved for initiation, monitoring, and adjustment of argatroban dosing. Conversion to warfarin dosing and monitoring was also included in the protocol.

Orbactiv (oritavancin) has been added to the formulary to replace Dalvance (dalbavancin) per restricted use criteria for acute bacterial skin and soft tissue infections as a long-acting single dose agent in patients who may warrant parenteral therapy but do not otherwise require inpatient management. Dalbavancin has been given 17 times since it was added to the formulary and only two of the 17 patients were readmitted to LVMC for cellulitis; both were 5 months after infusion.



Deletions:

Dalvance (dalbavancin) has been removed from the formulary and has been replaced by Orbactiv. Orbactiv has similar efficacy data with an improved cost profile.



By Chad Signorelli, PharmD

Updated CDPH Guidance clarified for healthcare settings regarding masking, screening & physical distancing. Because LVMC is a healthcare facility licensed by the California Department of Public Health, most of the relaxed guidelines do not apply to healthcare facilities and workers. See the table below for the current guidelines. The bottom line; We still need to practice source control, screening and continue to mask while inside the facility regardless of vaccine status. There are a few exceptions for fully vaccinated individuals such as when eating, during meetings and in breakrooms when all persons present are fully vaccinated. Please contact Infection Prevention and Control if you have any questions at extension 3359 or 3360.

by Melissa DeBacker
Chief Quality Assurance/ Risk Mgmt Officer

	FACE MASKS	PHYSICAL DISTANCING	SCREENING
CDPH REQUIREMENTS FOR HEALTHCARE FACILITIES:	"Masks are not required for fully vaccinated individuals EXCEPT in the following settings where masks are required for everyone, regardless of vaccination status: **Healthcare settings** & Long Term Care Facilities. Schools K-12 Shelters Correctional facilities, shelters (homeless & emergency cooling shelters)"	Cal OSHA refers healthcare workers/settings to State Licensing guidelines. See CDPH. CDPH/Cal OSHA state hospitals must follow the Aerosol Transmissible Diseases Guidance (ATD): ATD: Must have source control method procedures, planned, developed and implemented. Source control is defined in ATD as: "Source control measures. The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an ATD, such as persistent coughing"	Screen all vaccinated and unvaccinated persons who enter the facility. Persons who are symptomatic should not enter the building.

Excerpt from recent e-mail by our CEO regarding LVMC's published quality data, "HQI publishes a Quality Transparency Dashboard, which includes the five metrics shown below. I am very pleased to report that LVMC's performance is better than State and/or National averages in each of the five areas. And, LVMC is the only hospital in Santa Barbara County that can make that claim."

- Central Line-Associated Blood Stream Infection: ***Better than State and National Average***
- Colon Surgical Site Infection: ***Better than State and National Average***
- NTSV – Nulliparous, Term, Singleton, Vertex Cesarean Birth Rate: ***Better than State and National Average***
- Sepsis Mortality: ***Better than State and National Average***
- 30-Day Readmission Rate: ***Better than National Average***

Quality Transparency Dashboard

Excellent work, everyone...keep it up!!

Outcome Measures:*	CLABSI	Colon SSI	NTSV	Sepsis Mortality	30-day Readmission
Lompoc Valley Medical Center	0.00	0.00	19.00	5.88	15.50
California Level	0.67	0.86	22.90	13.50	15.48
National Level	0.69	0.87	25.90	25.00	15.60

Program Status Measures:	
x Yes No	This hospital has a Maternity Safety Program in place. A maternity safety program provides a coordinated approach and emergency response to risks associated with pregnancy and childbirth.
x Yes No	This hospital has a Sepsis Protocol in place. A sepsis protocol provides guidance for a coordinated approach to identification and treatment of an infection and inflammatory response which is present throughout the body.
x Yes No	This hospital has a Respiratory Monitoring program in place. Respiratory monitoring provides guidance for assessment of risk of respiratory depression, and includes continuous monitoring of breathing and functioning of the lungs and circulatory system when indicated.

***Definitions:**

CLABSI: Central Line Associated Blood Stream Infection

Colon SSI: Surgical Site Infection following certain colon procedures

NTSV: Nulliparous, Term, Singleton, Vertex: Cesarean birth rates that focus on first time mothers who's pregnancy is at least 37 weeks with one baby in the head down position. Note: NTSV rate does not take into account certain obstetric conditions that may make cesarean delivery the safest option.

Sepsis Mortality: Percent of patients with severe infection who die in the hospital.

30-day Readmission: The percentage of patients re-admitted to the hospital within 30 days of discharge from the hospital for any reason.

LVMC participates in patient safety programs including Sepsis, Maternal Safety, and Respiratory Monitoring.

Medical Staff Committee Chairs July 2021 - June 2022

Chief of Staff - Medical Executive Committee
William Pierce, MD

Secretary/Treasurer - Quality of Care
Kali Freeman, MD

Emergency Services
Steve Reichel, MD

Family Medicine
Brian Taber, MD

Infection Prevention & Control
Howard Gregersen, MD

Medical Education
Cindy Blifeld, MD

Internal Medicine
Ahmad Nooristani, MD

Medical Ethics
Lawrence Riemer, MD

OB/GYN
Rodney Huss, MD

Pediatrics
Mohammad Tabek Bakir, MD

Physician Well-Being
Cindy Blifeld, MD

Pharmacy & Therapeutics
Rollin Bailey, MD

Surgery
Faridi Sherieff, DPM

Medical Staff IT
Christopher Lumsdaine, MD

Recent Medical Staff Appointments

William K. Boland, MD
Emergency Medicine
Santa Ynez River Physicians

Daniel Liu, MD
Anesthesiology
Lompoc Valley Anesthesia Associates

Jennifer Vineyard, DO
Internal Medicine
Lompoc Health - North 3rd Center

David A. Zander, MD
Internal Medicine
Lompoc Hospitalist Group, P.C.

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Lompoc Healthcare District

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