

ELECTRONIC MEDICAL REPORTING



AGENDA



Electronic Medical Reporting September 4th, 2015 10 a.m. – 12 p.m.

Panelist	Agenda
<ul style="list-style-type: none">▪ Robert Rankin IT Project Manager ▪ Destie Overpeck Administrative Director ▪ George Parisotto Acting Chief Counsel ▪ Richard Newman Chief Judge ▪ Rupali Das, MD Executive Medical Director • Eduardo Enz CHSWC	<ul style="list-style-type: none">▪ 10:00 - 10:05 Introduction▪ 10:05 - 10:10 Goals▪ 10:10 – 10:20 Overview▪ 10:20 – 12:00 Discussion

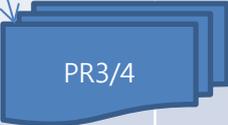
Electronic Medical Records Goals



Electronic Medical Records Goals

- Improve processing time in providing medical care
- Improve oversight, accuracy and accountability
- Expedite payments to providers
- Reduce administrative costs



Role	Report	Process	Summary
Physician			Generated by physician at every first patient encounter where an occupational illness/injury is suspected
Claims			<p>The RFA is generated at every visit if treatment is recommended and submitted to claims administrator. Only 1 RFA per visit, but multiple RFAs possible per worker.</p> <p>UR is conducted by claims admin to assess necessity of treatments – may be conducted by URO organization</p>
Worker			Worker submits IMR application along with UR determination to Maximus. Maximus requests medical records from claims admin
			
			Primary Treating physicians initial report and final reports of permanent disability

Area	Challenges	Benefit
<u>Forms/Reports</u> DFR RFA PR2 PR3 PR4	<ul style="list-style-type: none"> • Coordination between providers and claims administrations • Standard form/report format • Access to current data • Delays in processing 	<ul style="list-style-type: none"> • Timeliness of claims processing • Improves accuracy • Improved performance, reliability and scalability
<u>Process UR/IMR</u>	<ul style="list-style-type: none"> • Lack of access to current data for UR • Delay in decisions due to paper processes - IMR • No standardized report format/validations 	<ul style="list-style-type: none"> • Saves money and resources • Medical decisions for injured workers are faster • Better accountability • Better record/data tracking
<u>Process QME reports</u>	<ul style="list-style-type: none"> • Current reports are not electronic 	<ul style="list-style-type: none"> • Enhances quality of dispute resolution • Improves ability to review quality reports • Better access to data
<u>Process eBilling</u>	<ul style="list-style-type: none"> • Mandated process • Inconsistent adoption • Some data is electronic currently and some is not (PDF and attachments) 	<ul style="list-style-type: none"> • Expedites and ensures more timely medical bill payments • Higher productivity, lower operating costs

Medical Reporting Questions and Issues

DFR	Discussion
DFR current state? What is being done today?	
What is current capability (EDI, XML, other...)? Where do we start?	
Greatest challenges	
Ideal conversion time – transition to electronic reporting	
How capability is realized (in house, vendors, package software....)	
What could the DFR in the future look like?	

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS							PLEASE DO NOT USE THIS COLUMN Case No.	
2. EMPLOYER NAME								
3. Address		No. and Street		City		Zip	Industry	
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.)							County	
5. PATIENT NAME (first name, middle initial, last name)					6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	7. Date of Birth Mo. Day Yr.		Age
8. Address:		No. and Street		City		Zip	9. Telephone number ()	Hazard
10. Occupation (Specific job title)							11. Social Security Number - -	Disease
12. Injured at:		No. and Street		City		County	Hospitalization	
13. Date and hour of injury or onset of illness		Mo.	Day	Yr.	_____	Hour a.m. _____ p.m.	14. Date last worked Mo. Day Yr.	Occupation
15. Date and hour of first examination or treatment		Mo.	Day	Yr.	_____	Hour a.m. _____ p.m.	16. Have you (or your office) previously treated patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED. (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. SUBJECTIVE COMPLAINTS (Describe fully. Use reverse side if more space is required.)

19. OBJECTIVE FINDINGS (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. DIAGNOSIS (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? Yes No
ICD-9 Code _____ - _____

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? Yes No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? Yes No If "yes", please explain.

23. TREATMENT RENDERED (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? Yes No

If "no", date when patient can return to: Regular work ____/____/____ Modified work ____/____/____

Specify restrictions _____

Further Ideas/Questions?

Please email us at:

EMR@dir.ca.gov

