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INSIDE

ED-based interventions to break cycle among patients presenting with violence-related injuries

Unique trauma support program shows promise

Emergency providers have so much to do it is hard to justify adding one more task to their already full plates. However, when the right resources are in place, there is increasing evidence that EDs can play a

EXECUTIVE SUMMARY

Studies have shown that patients who present to the ED with violence-related injuries are at high risk of being involved in future violent incidents. Consequently, investigators say the ED is an ideal setting to intervene with these individuals with the kind of care and support that will lead them toward a safer path. Helping Hurt People (HHP), a hospital-based trauma support program developed at Drexel University in Philadelphia, PA, has been fulfilling this function at Hahnemann University Hospital and St. Christopher's Hospital for Children in Philadelphia since 2007, and now the program is being expanded to three other trauma centers, along with a research program aimed at documenting HHP's effectiveness.

- When a patient presents with injuries from an assault or other form of violence, ED personnel are encouraged to contact the HHP social worker who then follows up with the patient.
- Interventions offered through HHP include a range of social and mental health services such as behavioral health counseling, job placement assistance, help with housing, and educational guidance.
- Program administrators say HHP interventions have reduced symptoms of PTSD, depression, and anxiety, and that it has successfully linked many patients with health insurance and primary care.
- With expansion of the program to three new trauma centers, more comprehensive research is planned to document the program's effectiveness.

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pivotal role in preventing victims of violence from becoming enmeshed in a cycle that brings them or associates back to the ED with similar injuries again and again.

The risk of such repercussions is well recognized at this point. The latest study to take a look at the issue followed a population of adolescents and young adults with a history of drug use who presented to the ED with injuries from assaults. Investigators found that these patients had a 40% higher risk of reporting firearm violence within two years of their initial ED visit than peers who had no history of assault. Further, the researchers report that two-thirds of the incidents involving firearm violence occurred within six months of the ED visit.[1]

Investigators say these and similar findings highlight the opportunity that EDs have to intervene in a way that will point victims down a safer path, potentially preventing future incidents from occurring. Indeed, some hospitals have already taken steps to identify patients who present to the ED with violence-related injuries and link them with care and support aimed at short circuiting the cycle that leads so many victims of violence to seek retribution or to be victimized again.

Identify patients at risk

For example, Helping Hurt People (HHP), a hospital-based trauma support program developed by the Center for Nonviolence and Social Justice at Drexel University in Philadelphia, PA, has been actively intervening with victims of violence in the ED at Hahnemann University Hospital and St. Christopher's Hospital for Children in Philadelphia, PA, since 2007.

"We have a program manager and then there are two social workers who are committed to working not just in the hospital but also in the community," explains **Theodore Corbin**, MD, MPP, the director of HHP, and an associate professor in the Department of Emergency Medicine in the College of Medicine at Drexel.

Corbin explains that when patients present to the ED with injuries from an assault or another form of violence, emergency personnel are encouraged to contact HHP. "They all have cards and numbers where they can reach our social worker," he says. "Monday through Friday, between the hours of 9 and 5, are when our staff are on the premises."

If a victim of violence comes to the ED after these hours, then this will be noted in the electronic medical record (EMR) so that one of HHP's social workers can follow up with the patient the next day, explains Corbin. "The social worker will come in every day and go through the log to see if there is anyone who has been flagged," he says. Further, while the ED is the main point for patient identification, HHP also provides information to the hospital's surgical nurses and trauma surgeons so that they are equipped to refer patients to the program as well.

The range of services and support offered to patients through the HHP program varies depending on what they need. "Someone's needs could be very minimal because they have other supports in their lives whereby they might just need a simple referral to a primary care physician or a connection with health care," says Corbin. "Others will have a bit more complexity in their lives and situations, and they will benefit from other services."

These may include such services such as behavioral health counseling, substance abuse treatment, job training and placement, parenting education and support, housing, and legal help. "What we emphasize is the trauma that people experience, and not just the physical aspects of it, but the psychological and emotional aspects of it as well, and how [these aspects] have impact on a person's physiology," observes Corbin.

Clinicians who have experienced or witnessed violence may have some understanding of this longer-term impact, observes Corbin. "I see a lot of this on a regular basis, but I have a support system in place that allows me to decompress, move through, and move on," he says. "But some of the young people who are plagued with this chronic stress and adversity on a daily basis don't have support systems in place to help them move past and move through these experiences."

Collect pre- and post-intervention data

Results from the HHP intervention have not yet been tabulated in a scientific way, but they have been observed, advises Corbin. "What we are noticing is that we are decreasing the propensity to develop PTSD [post-traumatic stress disorder] symptomatology … and we are decreasing symptoms of depression and anxiety," he says, noting that other more tangible results include connecting patients with health insurance and primary care.

While anecdotal, these results have nonetheless attracted the attention of other hospitals in the area. Indeed, with funding from Philadelphia's Department of Behavioral Health and Intellectual Disability Services (DBHIDS), HHP is now being expanded to the EDs at Temple University Hospital, The Hospital of the University of Pennsylvania, and Einstein Medical Center, a move that will eventually make HHP available city-wide. Further coupled with this expansion is the opportunity to collect the kind of hard data needed to convincingly demonstrate the program's effectiveness.

For example, while Einstein Medical Center is still in pre-implementation mode, it is also collecting data about current patients who present to the ED with violent injuries and get usual emergency treatment. "We will then follow up with them at six weeks, six months, and a year to see what kind of health and psychosocial outcomes they are having," explains **James Gardner**, MD, an attending physician in the ED at Einstein Medical Center and the champion of HHP for this facility. "And then once the program is actually implemented, we are going to gather the same data on patients … to see if we are actually making a difference in outcomes between before and after we have the program in place, so it is a … unique opportunity to do this kind of effectiveness research."

This type research is also going on at the other trauma centers that are putting the HHP program into place. "We are implementing the program at these four hospitals and doing the research at these four hospitals, so we should have a pretty big database at the end of the research implementation [to show] how well this works," observes Gardner. "What we are looking at is a broad array of outcomes that we know are associated with violent injury."

For instance, Gardner notes that researchers will be looking well beyond the traditional medical measures, such as how well a wound has healed or what changes have occurred in a patient's disability status. "We know there are a lot of psychosocial problems that go along violent injuries, and that when these predominantly young men present to the ED after they have gotten in a fight or got assaulted or got shot or mugged ... a lot of times that is the tip of the iceberg of a lot of other underlying problems, both for them personally and for the communities they come from."

Consider psychosocial outcomes

Many of the patients who present with these types of injuries have led traumatized lives, adds Gardner. "Oftentimes when they are coming into the ED, that is not the first time they have been victims of violence, and it is not the first time they have seen violence," he says. "Their families and their friends have been involved in [violence] and been victims of it, and they have had involvement in the criminal justice system, so we see the presentation to the ED as kind of the index case where we can identify that here is someone who is at risk in all of these different ways."

In such cases, the visit to the ED may be the only time that these individuals actually come to medical attention, so it is an opportunity to potentially intervene, explains Gardner. "In terms of outcomes, we are looking at everything from rates of PTSD to substance abuse to further involvement in the criminal justice system, either as repeat victims or perpetrators," he says.

Also on the radar are job and educational-related outcomes. "These are all things that we try to address

in the program, and they are all outcomes that we are looking at to see if there is improvement in them as a result of their participating in the program," observes Gardner.

While HHP has a heavy social-work focus, it does not duplicate any of the services already provided by hospital-based social workers, according to Gardner. "We have excellent ED social work staff and trauma social work staff, but they tend to be pretty thinly spread, and they are focused on fairly immediate needs," he says. "They can do brief evaluations and referrals, but they don't really have the time to engage with patients in a more in-depth way, which I know is a frustration for them."

However, HHP provides the resources and the staff to dedicate much more time on each of these patients, says Gardner. For example, some of the program interventions are designed to address basic, pragmatic needs such as assessing what a patient's ongoing health and financial needs are, and making sure they have follow-up appointments, transportation, and help with navigating the health system. "These basic [things] can be surprisingly challenging for some of these patients," notes Gardner.

However, there are also interventions designed to address the underlying psychological issues that often go along with violent injuries. "A lot of these patients have past traumatic experiences going all the way back to childhood," says Gardner. "They can often have pretty significant PTSD related to the injury that brought them to the ED."

To address these issues, patients can receive individual therapy as well as weekly group sessions where they will engage with other members of the program, explains Gardner. "One problem with a lot of these patients is that they don't have a vision for their future," he says. "There is an assumption that they are going to end up dead at a young age, and that they won't have opportunities. That can be a self-fulfilling prophecy."

Develop billing strategies

Corbin estimates that the ED at Hahnemann University Hospital sees about 90 patients a month who present with interpersonal injuries and that HHP connects with at least 50 of these individuals. Gardner is anticipating that the program being developed at Einstein Medical Center will screen several dozen patients every week, eventually connecting with about two dozen patients a month, although there are likely to be seasonal fluctuations in the volume. "The violence that we see really spikes during the summer; it lays off a bit in the winter," says Gardner.

While most of the funding for the program is coming from DBHIDS, one goal of program developers is to make the program mostly self-sustaining by seeking reimbursement for some of the social work and psychological interventions that HHP delivers.

"We feel like these clinical interventions have similar public health benefits to a lot of other things we do and should be reimbursed similarly," says Gardner. "One thing which I think is very clear in the literature but continues to be underappreciated as a matter of public policy and health policy is how central mental health is to health outcomes — and particularly in the ED."

For instance, Gardner points out that there is a mental health component to many of the conditions that emergency providers see every day. "Everything from cardiovascular disease to diabetes to alcohol and drug abuse — all of these things, in one way or another, get tied either directly or indirectly to behavioral health and mental health risk factors," he says. "I think in some ways we see so much of this in the ED that we almost kind of forget that it is there, but it really is a big component of what we do."

Gardner says he is very enthusiastic about trying to move ED physicians, ED administrators, and payer mentalities toward recognizing how important mental health issues are to both longer-term outcomes and costs. "If you pay some attention to these issues on the front end, you potentially prevent far larger financial expenditures on the back end, and so that is one thing we are hoping to demonstrate in this before-and-after research," he explains.

Re-admissions due to subsequent violent injuries, higher rates of substance abuse, further development of mental health issues, and repeat involvement in the criminal justice system are all tremendously expensive outcomes both for the health system and society, stresses Gardner. "Any prevention [of these things] on the front end with what is a relatively inexpensive intervention up front should really be worthwhile, so we are hoping to be able to demonstrate that to government and to payers as well," he says.

Facilitate referrals

Far from getting pushback, plans for the program at Einstein Medical Center are getting an enthusiastic response from both hospital administrators and emergency

providers thus far, explains Gardner. "We all recognize this as an issue and an unmet need," he says. However, Gardner also emphasizes that program administrators are trying to make referrals to HHP as easy as possible for providers.

"I would like this to be something they think of in the same way as when they refer a patient to cardiology if someone comes in with shortness of breath or orthopedics if they come in with a broken wrist," says Gardner. "This should be a similar kind of triage and referral process like we do with every other problem that we see in the ED, and I think we are actually going to make it just as easy, if not easier than the referral process for those other conditions."

Further, while HHP will be based in the ED, the program is really a multi-department effort, says Gardner. "The Department of Psychiatry is involved, the Department of Social Work is obviously involved, and the Trauma Department is involved, so it is [an opportunity] for cross-department collaboration," he observes. "That is pretty exciting as well — getting people from all their different silos to work together on these patients."

With four large trauma centers now involved in HHP, researchers and administrators have an opportunity to share best practices in terms of planning and implementing the program. It is also clear that hospitals in other regions are eyeing the approach. Indeed, developers note that a few hospitals in Illinois and Oregon have also moved to replicate the program.

However, even at Hahnemann University Hospital, where HHP has been in place since 2007, the model requires ongoing education and reinforcement. "On a quarterly basis we do in-service sessions for the nurses, both in the ED as well as those who are in the trauma unit and on the med-surge floors. Then also for the physicians we do brief presentations about the work, and often we bring in some of the young people that are in involved in the program and let them talk to the physicians about their experiences," says Corbin. "Especially at this time when [there is such a strong focus on] patient satisfaction, it is good feedback for physicians to know what worked well and what didn't." ■

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Study: Emergency providers often lack consensus on what patients intend when end-of-life forms come into play

Experts say more training, awareness needed to clear up confusion

A new study suggests there is a lack of consensus or understanding about what patients intend when they fill out Physicians Orders for Life Sustaining Treatment (POLST) forms, and that this likely leads to patients either receiving or not receiving treatment contrary to their wishes. Investigators suggest more training on these issues is needed, and recommend that clinicians take the time to clarify choices during periods of critical illness.

A new study found that when presented with a range of clinical scenarios coupled with POLST forms reflecting patient wishes, emergency providers did not often reach a consensus on what actions they would take.

Researchers say that "do not resuscitate" orders are commonly misinterpreted to mean do not treat, and there are also practice and regional variations in how end-of-life-care documents are interpreted.

While a national organization establishes POLST recommendations and sample policies, the documents themselves are established and regulated at the state level, along with training procedures.

Experts recommend that hospitals establish quality control procedures to

ensure that end-of-life care documents are prepared and interpreted accurately.

There is new evidence that both emergency physicians and prehospital providers struggle, at times, to correctly interpret end-of-life-care instructions spelled out in POLST documents. In a study led by **Ferdinando Mirarchi**, DO, FAAEM, FACEP, medical director of the Department of Emergency Medicine at the University of Pittsburgh Medical Center (UPMC) Hamot in Erie, PA, investigators discovered that many care providers find the POLST forms confusing; as a result, the care choices indicated in the POLST forms are likely not always carried out in the way patients intended.[1]

To conduct the research, Mirarchi and colleagues surveyed members of the Pennsylvania chapter of the American College of Emergency Physicians (ACEP) to gauge their understanding of the POLST documents. In the survey, both physicians (223) and prehospital providers (1,069) were presented with various clinical scenarios involving critically ill patients along with POLST forms indicating the patients' choices regarding resuscitation and treatment. Participants were then asked to state how they would respond in each clinical scenario.

Investigators evaluated rates of consensus, which they defined as 95% agreement, in each clinical scenario, and found that there were many instances in which the participant responses indicated a much lower level of agreement on what the various POLST instructions meant. In fact, in a majority of the clinical scenarios presented, the responses by both the physicians and the prehospital providers did not reach consensus levels.

Recognize variations in practice, understanding

For instance, when POLST forms specified DNR (do not resuscitate) with comfort measures only, 10% of physicians and 15% of prehospital providers indicated that they would still perform cardiopulmonary resuscitation (CPR). Mirarchi explains that some of this disagreement likely comes from a common but misapplied interpretation of what DNR means. "'Do not resuscitate' orders are equated with 'do not treat' orders or assumptions, 'do not operate' orders or assumptions, or end-of-life-care treatment," he says. "That has been a known misunderstanding for many years now."

There may also be regional or practice-level variations in what DNR orders are meant to convey, and just a general lack of education or training on when and how DNR orders should come into play, observes Mirarchi. "Take, for example, someone who is 60 years old and has a heart attack. At that point in time, it is a very treatable process," he explains. "Now, if the patient goes into sudden cardiac arrest, that is another reversible, treatable process, especially if it is witnessed, so that is a person who would very rarely give consent to not having their treatment."

However, when living wills or POLST documents are introduced into these types of scenarios, there is a high likelihood that patients will not receive the care and treatment that they would be expected to receive, explains Mirarchi. "Most of these documents have different connotations. A living will is not a DNR order. Those documents can exist together. A living will can exist with a DNR order but, by and large, a living will is not a DNR order," he says.

On the other hand, a POLST form can be a DNR order because

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- Researchers say that "do not resuscitate" orders are commonly misinterpreted to mean do not treat, and there are also practice and regional variations in how end-of-life-care documents are interpreted.
- While a national organization establishes POLST recommendations and sample policies, the documents themselves are established and regulated at the state level, along with training procedures.
- Experts recommend that hospitals establish quality control procedures to ensure that end-of-life-care documents are prepared and interpreted accurately.

of the way it is structured and formatted, and this is where a lot of the confusion comes in, notes Mirarchi. "What people think they put into a form may not have the desired effect. It may have a completely opposite effect, depending on the understanding of the person reading the form, if, in fact, they have actually read the form," he says. "Oftentimes, we find out that people don't read the forms. They think they have an understanding of what the form is, and then they act or don't act depending on what their perceived understanding of what the form is."

For example, Mirarchi recalls the case of a 67-year-old man who had a living will. "When he met with his attorney, [the lawyer] essentially said the document would only come into play when there is nothing else [clinicians] can do for him in medicine," he says. However, when the man suffered a myocardial infarction (MI), it almost went untreated because of someone's misunderstanding of the living will document, adds Mirarchi.

In these types of circumstances, clinicians may equate having a living will with a patient not wanting life-saving care, even in cases in which the patient has a very treatable condition, explains Mirarchi. Clinicians may feel as though they are following the patient's wishes when that is not the wish of the patient at all, he says.

Take steps to verify choices

To prevent such misunderstandings from leading to unwanted or tragic results, Mirarchi created a checklist that emergency clinicians can use whenever POLST or other end-of-life care documents are introduced in the midst of a resuscitative scenario. "Most people think of resuscitation as [involving] just cardiac arrest patients, but that is not the case anymore," says Mirarchi, noting that things like sepsis, stroke, and trauma all have processes and activation teams that come in and immediately resuscitate patients. "When you introduce these documents into those scenarios, that is when people are at risk to either be over-treated or under-treated because of provider misunderstanding of those [end-of-life care] documents."

The checklist, which clinicians can remember by the letters A, B, C, D & E, involves:

- **Asking** patients or their surrogates to be clear about their intentions with respect DNR orders, POLST, or other living will documents;
- **Being** clear as to whether the patient has a terminal condition or a critical illness that can be treated;
- **Communicating** whether you think the condition is reversible with a good or poor prognostic outcome;
- **Designing** a plan of care and discussing the next steps;
- **Explaining** that it is OK to withhold treatment or to withdraw care if that is consistent with the patient's wishes, and what the benefits are of palliative care and hospice are.

Mirarchi says that he is now accustomed to running through the early part of the checklist quickly to determine whether or not he needs to treat a patient, and he trains residents and attending staff to incorporate the process into their decision-making capacity as well. "Very rarely anymore do we have an instance where someone is under-resuscitated or over-resuscitated," he says.

One of the issues with advance directives is that people tend to ignore them, but Mirarchi notes that often they are not ignored; it is just that they have not been activated yet. "They have not been triggered yet because we don't [have all the information] at that point in time," he says. "In that instance, you institute care and treatment and you essentially start to de-escalate when you get more information, and then make things more appropriate for the patient and their family."

However, Mirarchi notes that the study makes clear that much more needs to be done to improve awareness, education, and training in how end-of-life care forms should be used and interpreted. "By far, it shows that there is still a lot of confusion with these documents in the setting of critical illness," he says. "And the treatments that are provided often lack consensus for some of the most commonly treated critical illnesses that we see everyday in the ED."

Consider national standards, recommendations

Bringing widely recognized standards to the way POLST documents are structured and used is complicated by the fact that every state makes its own policies, procedures, and rules. For example, while most states require POLST forms to be signed by a physician, that is not true in every case. Further, the forms vary from state to state and, in some cases, the content of the forms is dictated, at least in part, by legislative statute.

Despite these state-level variations, the National POLST Paradigm, based in Portland, OR, provides guidance and an endorsement process aimed at getting the states to use POLST documents in a consistent and effective way. "We encourage

the states to contact us the minute they are thinking about establishing a POLST program," explains **Amy Vandenbroucke**, JD, the executive director of the National POLST Paradigm. "We have a developing state assistance committee, and that committee is a group of people that [come from] states that have been endorsed and are very familiar with the tenets of the POLST program and what it takes to be endorsed, so we work with states to try to get them to reach that endorsement level."

What endorsement means is that a state's POLST program has been implemented in a form that complies with requirements that have been established by the national POLST paradigm task force, explains Vandenbroucke. For example, she notes that POLST programs should only be reaching out to patients who are ill or frail and someone their health care professional would not be surprised if was dead within a year. It is also important to insure that POLST forms are always voluntary, and that states have the right people at the table when they are devising their programs, adds Vandenbroucke.

Currently, a POLST program is in some level of development in 48 states, with 17 state programs having achieved endorsement level, says Vandenbroucke. "Endorsement doesn't mean a program is at a statewide level. It just means that the state is working toward a statewide program," she says. "It means that we are concurring that the [POLST] form and the program are meeting our standards."

Similarly, while the national organization does not offer training to clinicians or others involved with preparing POLST documents with patients, it does facilitate connections to resources. "For example, California has a very good train-the-trainer program. The state has done a good job implementing it, and they have really good materials," says Vandenbroucke. "So if states are looking to do something, and they talk to me, I might connect them to the California program."

Vandenbroucke notes that both Hawaii and Maine have taken the California program materials and are adapting them for their own states. "States don't need to reinvent the wheel, but the national office has not independently created those kinds of educational materials just yet," explains Vandenbroucke.

Establish quality control procedures

Judy Thomas, JD, the chief executive officer of the Coalition for Compassionate Care of California (CCC) in Sacramento, CA, explains that the group developed a two-day training program on how to have a POLST conversation. "The form is only as good as the conversation," she says. "The form just documents the conversation."

Since CCC cannot go to every community, it has trained more than 900 people on how to train others to conduct the POLST conversation. "We have 25 local coalitions around California that work at the local level," says Thomas. Further, when problems with the process or the form crop up, these local coalitions serve as CCC's eyes and ears. "When they need clarity from the state, they let us know," she says.

The group has developed model policies and procedures for hospitals, nursing homes, and hospices, and it has developed brochures about POLST for both consumers and providers. However, she notes that the types of issues referenced by Mirarchi are not necessarily a problem with the POLST process but rather a sign that clinicians may not be in agreement on many of these issues. In particular, clinicians outside the ED, who work more frequently with patients having terminal illnesses, are in need of education and clarity.

"We heard that before POLST, people thought that DNR meant don't do anything, so that is one of the reasons why we like POLST, because it doesn't just talk about DNR, it also talks about other medical interventions to give a somewhat more nuanced understanding of a patient's wishes," says Thomas. "Also, in California, we felt that if someone does want resuscitation attempted, then they are basically buying into the whole process, which could mean intubation in the ICU ... so people need to understand that the instructions on attempted resuscitation can lead to that."

Not every state has agreed with this interpretation, so there is a lack of consensus in the larger clinical community. And Thomas acknowledges that the process of educating hundreds of thousands of physicians and nurses in all of the hospitals and nursing homes in California is challenging.

What can hospitals do to insure that staff are interpreting and using POLST forms correctly? Thomas recommends that administrators develop quality-control procedures, including a chart audit process to insure that the forms are being filled out completely and accurately. She also suggests that clinical leaders regularly include cases involving end-of-life care instructions when they make grand rounds. "There are opportunities to identify real situations involving POLST forms that either went well or could have

gone better," she says. "Use them as a training opportunity."

In California, a physician leadership council for POLST is set up as a mechanism for physicians to have regular input on the POLST process. "Each of our local coalitions need to have a physician champion or leader because this is a physician forum," says Thomas. "We have about 25 physicians who meet via conference call every month and they talk about all sorts of issues."

Consequently, when problems or issues are identified at the state level, they go to this group for consideration, says Thomas. "If there is some confusion, or we need clarity, we can get guidance," she says. ■

Editor's note: For more information or resources regarding POLST implementation, visit the website for the National POLST Paradigm at www.polst.org.

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SOURCES

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ED CODING UPDATE

Clean up coding practices to maximize revenue, minimize compliance issues, and be optimally prepared for ICD-10

[This quarterly column is written by Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, President of Edelberg Compliance Associates, Baton Rouge, LA.]

Having enjoyed numerous conversations over the past few months with industry executives expressing concern with how to prioritize the revenue cycle operations of the ED, I thought I might provide some talking points for ED directors in their next meeting with coding and billing managers to assure that compliance and revenue objectives can be met appropriately.

Top hospital billing and coding issues

Coding and HIM: ICD-10 implementation is the number one priority for nearly every hospital we speak with. It is important that all systems are a go for HIM coders to be able to assign ICD-10 codes for ED services. Be sure systems are tested with related ED ICD-10 codes for all the diagnoses we manage. It is also important to implement parallel coding for all coding professionals assigned to the ED to assure we don't lose valuable time and revenue through coding errors.

Charge Description Master (CDM): Too many hospitals across the United States have limited listings of ED services in their CDMs. Many do so because the processes necessary to add service codes to the CDMs are too complicated and time consuming. Millions of dollars in revenue are lost each year due to incomplete CDMs or through use of facility-assigned combination codes that include multiple ED services under one CDM code that would be separately billable and payable if identified separately. Clean up of the CDM is essential to assure maximum ED revenue. Services performed in the ED are billable through identification of each unique service with appropriate codes.

Coding Policy for Bundling and Unbundling: Too many issues remain unresolved about which ED services can be billed separately and which must be "bundled" into one all-inclusive service. As a result, many billable services are excluded from billing because of a lack of accurate information about what can be billed separately. For the most part, payers require itemization of services on billing forms. Payer software generally bundles the services that are included in service packages

unless appropriate modifiers are assigned by coding staff. Payment is then generated according to internal processing rules. To assure your procedures and services are billed appropriately, assign one individual to monitor payer information about up-to-date requirements for bundling and unbundling. Be sure you review up-to-date codes and descriptors in CPT 2015 and through the Medicare HCPCS unique code listings.

Documentation of Physician Orders: For a nursing service to be billed as part of the ED hospital bill, there must be physician orders and nursing confirmation that the services were actually rendered. Verbal orders that are not documented are not billable. Audit your ED records on a routine basis to assure that only the services that were ordered and performed are actually billed.

Signed Records: Records must be signed by the physician(s) responsible for the services provided. Check to see how many unsigned records there are in your ED, and put in place processes to assure that no records are released for billing until complete and signed. Encourage physicians to review the entire record before signing to be sure all documentation, including macros, voice recognition entries, and templated statements are correct and appropriate.

Documentation of Provider Bedside Time for Critical Care: Under OPPS, the time that can be reported as critical care is the time spent by physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or injured patient. If the physician and hospital staff are simultaneously engaged in this active face-to-face care, the time involved can only be counted once. Documentation of this bedside care presents a challenge for most ED staff who may not understand how this can best be entered into the record. It is imperative that a statement summarizing the bedside care and/or detailed entries into the medical record for each bedside episode of critical care be documented into the record and signed or initialed by the responsible provider.

Infusions and Injections: Start and stop times must be entered by nursing personnel for each infusion in accordance with Medicare policy. Nursing staff must assure that these times are entered accurately in order to facilitate coding of these services. Significant revenue is lost each year from failure of nursing staff to document times accurately.

Top physician billing and coding issues

ED Level of Service and Medical Decision Making: Be sure your coding staff understands how to "score" risk and management options in accordance with your internal policy, with an eye on how your local MAC looks at MDM. The MDM content was developed for all medical specialties and is not specific to emergency medicine, so some interpretation is necessary to assure your coding of MDM reflects the services you provide. Check out the ACEP reimbursement FAQs for help in understanding how MDM works for emergency services.

Billing for EKG Interpretations, Ultrasound, and X-ray Interpretations Performed by EPs: Your group will need to establish a policy to determine documentation requirements for billing of these services. Policy should address: 1) content of the documentation required for categories of interpretations; 2) which payers you will bill these services to; and 3) which physicians are credentialed to provide these services.

Critical Care and Additional Procedures: Critical care requires that documentation identify the critical illness or injury being managed, the critical decisions made, and the time spent by the ED providers to manage the critically ill or injured patient. Documentation often fails to provide the time spent by the ED physician managing these patients. In addition, the "split/shared" visit rules do not apply to timed services. Thus, the time spent by either the physician or the advanced practitioner can be used to support the critical service, but not the elements of time spent by both. Where services provided by teaching physicians with the assistance of residents is concerned, only the time spent by the teaching physician can be used to determine the total time spent. The time spent by residents cannot be used toward meeting the time requirements for critical care.

Some procedures are included in the critical care package, but most are not. Consult the 2015 edition of the CPT manual published by the American Medical Association for a listing of these procedures.

Template, Voice Recognition, and Cloned Documentation: More and more payer audits are identifying cloned documentation that is used on many, if not all, patients. When it comes to compliance, this is a high-risk practice. Documentation must be individualized for each patient. Macros are OK as long as they are pertinent to specific findings for individual patients. Voice recognition can create significant problems as well.

Take a look at these actual medical record entries via voice recognition that were not modified

by the emergency physician:

• **ED Course:** Patient was seen and evaluated. Secondary to his recent trauma as well as his cardiac history, a workup was performed. An EKG was performed that showed a sinus rhythm at a rate of 61 beats per min and PR interval is 224 and consistent with a first-degree AV block. Uterus is 98 QTC 398.

• He bought something left in the store and Nexium remembers was laying on the ground with bystanders picking him up. Patient denied any chest pain, shortness of breath, headache prior to the episode.

• History of Present Illness (HPI): Patient is a 3-year-old male who presents to the emergency department with increased weakness. Patient lives at an assisted care facility.

• Consultant did present to the ED and interrogated the patient.

• He does have an ileostomy bag and has been scratching and removing the bags that are attached. Per family members present, the patient has removed multiple plagues on a regular basis and needs himself with stool all over.

Lesson to be learned? Keep a close eye on the performance of all processes in your ED to assure you are minimizing compliance risk and generating revenue from accurate billing of all services. ■

CNE/CME OBJECTIVES

After completing this activity, participants will be able to:

1. Apply new information about various approaches to ED management;
2. Discuss how developments in the regulatory arena apply to the ED setting; and
3. Implement managerial procedures suggested by your peers in the publication.

COMING IN FUTURE MONTHS

- These future months text bullets have the "Future months" Paragraph Style applied.
- A link between workplace violence and MSDs?
- Renewed push for a national safe patient handling standard
- Overcoming barriers to safe patient handling

ED MANAGEMENT®

CNE/CME INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right, or log onto AHCMedia.com and click on MyAHC. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice, or renewal notice.

3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.

4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.

5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly

CNE/CME QUESTIONS

1. **One new study found a population of adolescents and young adults with a history of drug use who presented to the ED with injuries from assaults had what percentage of risk of reporting firearm violence within two years of their initial ED visit compared to peers who had no history of assault?**

   A. 10% higher
   B. 20% higher
   C. 30% higher
   D. 40% higher

2. **According to Theodore Corbin, MD, MPP, the Helping Hurt People (HHP) program emphasizes how the psychological and emotional aspects of the trauma that people experience have an impact on:**

   A. health care costs
   B. a person's physiology
   C. the ability to thrive
   D. repeat visits to the ED

3. **Corbin estimates that the ED at Hahnemann University in Philadelphia, PA, sees about _____ patients a month who present with interpersonal injuries and that HHP connects with at least _____ of them.**

   A. 90, 50
   B. 80, 30
   C. 70, 35
   D. 90, 40

4. **In a study led by Ferdinando Mirarchi, DO, FAAEM, FACEP, investigators discovered that many care providers find Physicians Orders for Life-Sustaining Treatment (POLST) forms:**

   A. incomplete
   B. contradictory
   C. confusing
   D. all of the above