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Inside

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New HCFA rules may cut reimbursement up to 15% for outpatient services

Brace for 'double whammy' if costs go up and payments are cut

New billing regulations for Medicare patients would have an unprecedented impact on your ED's bottom line, according to experts interviewed by *ED Management.* The proposed regulations would lower reimbursement and put some EDs in financial jeopardy, predicts **Michael Bishop**, MD, FACEP, vice president of the American College of Emergency Physicians (ACEP) in Dallas.

"Obviously, if you cut up to 15% of patient reimbursement for emergency services, that will have a significant financial impact on the hospital," Bishop says. "If your costs are going up and your payments are cut, then it's a double whammy." ED managers will need to provide the same services for less money, which is a formidable challenge, he explains.

The financial impact may be so devastating that some hospitals may have to close their doors. "You need to be concerned about the financial viability of your institution," warns **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "There could be huge shifts in volume of outpatient surgery in competitive markets. The need to meet the competitive price may affect the financial viability of the institutions, and it will definitely affect their cash flow."

"This is so broad-sweeping, it has potential financial ramifications for literally every ED in the country," emphasizes Bishop, who served on an ACEP task force that commented on the regulations. **(See excerpt of ACEP's comments, p. 91.)**

The long-awaited plan from the Health Care Financing Administration (HCFA) in Baltimore will shift outpatient reimbursement for hospitals into ambulatory patient classifications (APCs) similar to the diagnosis related groups (DRGs) for inpatient payments.

The proposed system groups more than 5,000 outpatient codes into 346 payment groups, or APCs. "Each APC has been constructed to include a related group of clinical services for which Medicare will reimburse hospitals at a single, predetermined rate," Smith explains. "So APCs substantially reduce the number of payment levels that need to be tracked."

To define the clinical services included in each APC, HCFA will use the same coding system currently used to reimburse physician services for

Medicare patients, known as the current procedural terminology (CPT) system.

"This would be a major change in how billing is done. It represents the same magnitude of change as the switch DRG has had on the inpatient side," says **Charlotte Yeh**, MD, FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA.

This is the biggest reimbursement change in Medicare billing since 1982, when the Tax Equity and Fiscal Responsibility Act was passed, Bishop says. "That caused many emergency physicians to do their own billing instead of the hospital. This change will have no less of an impact on EDs."

The regulations will control the growth of Medicare expenditures for hospital outpatient services the way the DRG reimbursement system controlled inpatient expenditures. "The Medicare strategy is simply to treat hospital outpatient services exactly the same way as they treat physician office services, which is a totally new approach," Smith says.

Explains Bishop, "This is a move by HCFA to decrease Medicare costs, which is not a bad thing, but there are potential problems. In the ED, we can't control the patients we see, so we see the sickest patients. If the amount of revenue goes down for the hospital, we will have less money to provide the same services."

As a result, patient care could be affected. "This can certainly affect patient care if there is not as much money coming in to the hospital. Decreased payment could result in decreased staffing, equipment, and supplies," Bishop says.

Some hospitals will be affected more than others, he warns. "Teaching institutions and large inner-city hospitals, any hospital that has a high percentage of high-acuity or Medicare patients, will be hit the hardest."

Hospitals should expect less payment for outpatient services provided to Medicare beneficiaries, both from Medicare payments and copayments from beneficiaries, says Smith. "HCFA predicts reductions in direct payments from the Medicare program amounting to 3% to 15% of current revenue. The actual impact on individual hospitals will vary based on the hospital's current cost-to-charge ratio."

Although ED patients already are guaranteed access to care under the Emergency Medical Treatment and Active Labor Act (EMTALA), financial ramifications could create barriers to care, Yeh stresses. "If the payment levels are insufficient, you might not only see hospitals closing, but some hospitals may pull out of outpatient and emergency services," she predicts. "If that happens, it will create an access problem."

Copayments will be reduced from current levels by an unspecified amount. "Estimating the amount of this reduction is very difficult," says Smith. "Comparing the maximum and minimum copayment amounts for common procedures suggests that the eventual reduction will average 13% of total payment. More than 50% of the revenue reduction will result from lower beneficiary copayment."

The impact on hospitals will depend on the amount of copayment they charge. "A hospital has to choose whether to charge the maximum or minimum allowable copayment, or some number in the middle," says Smith.

Keep on top of this issue

Keep your staff informed so the change doesn't take them by surprise. "Most ED physicians don't know much about this, so ED managers need to get the word out that this is coming. Inform staff and hospital administrators about the potential ramifications of this," urges Bishop. **(See story on concerns for emergency medicine, p. 89, and ACEP's commentary, p. 91.)**

Also, keep abreast of new developments, Yeh recommends. "ED managers should stay in touch with hospital administrators and work with trade associations like the American Hospital Association [AHA] and the American College of Emergency Physicians to make sure our voices are heard."

Many ED managers are unprepared for this change, says Smith. "It is a sleeping issue because it's been expected for so long and has been put off so many times," he explains. Implementation originally was scheduled for January 1, 1999, but the date has been moved to April 2000.

A draft of the proposed regulations was published by HCFA, and comments on the preliminary rules are being reviewed, notes Smith. The final rules will be published 90 days before implementation. The delay is

due to HCFA's problems with the Y2K computer bug.

"Hospitals will need the intervening months to prepare for the operational changes required for billing of outpatient services and to plan their response to the market changes that the new Medicare payment system is certain to cause," says Smith.

EDs may come out ahead

Although the overall impact on hospitals will be negative, it's possible that EDs may benefit from the change financially as individual departments, says Smith. "The EDs are actually going to come out ahead rather than behind, because in general they do less-complicated cases, compared to the rest of the hospital," he explains. "EDs do have very complicated medical cases, but there is a built-in filter so we don't get the worst surgical cases."

The change will directly increase the revenues attributed to the ED. "The ED will become a revenue center instead of a loss center," he predicts. "For example, for an IV administered, right now the only payment the average ED gets is whatever is included in that visit level."

When the new regulations take effect, EDs will get credit for both the visit and the procedure. "If that IV is billed under a revenue code for the pharmacy, then the charge will be denied because it's bundled into the visit service," Smith says. "The $100 paid for that IV needs to be billed by the ED revenue code, not under the pharmacy code."

The ED then gets credit for the payment, Smith explains. "So the pharmacy becomes a supplier of material to the ED. The gross revenue of the ED will go up, and dramatically down for the pharmacy," he says.

If HCFA decides to make its payment decisions based on the patient's symptoms and services received instead of the eventual diagnosis, that could be a positive change for emergency medicine and patients, Yeh says. "We will finally have some policy recognition that a diagnosis is not what drives emergency care," she explains.

If the fee schedule allows for payment for services required under EMTALA, including medical screening exams and stabilization, that would be another plus, says Yeh. "There should be some payment recognition for EMTALA-mandated services, which we have an obligation to provide," she stresses.

The commentary process provided an opportunity for ACEP to collaborate with the AHA, she reports. "We have continued to build a working relationship so we can improve the consistency of our comments. In the draft version, AHA deferred to ACEP's point of view on several issues, which highlighted that we are working together toward a common goal."

Here are the two major changes that EDs are expected to make in response to the regulations:

1. **The existing cost-based reimbursement will be replaced with a prospective payment system.** Hospitals will be required to report outpatient service charges using a standardized coding system. ED charges will be submitted based on the APC coding system for procedures. "HCFA's reporting structure is the same one currently in place for physician services," Smith explains.

Currently, Medicare pays emergency departments for supplies and medications used in a procedure, not the procedure itself, notes Smith. "Now Medicare will pay for the service of injecting a drug, instead of paying for the drug or supplies consumed in a procedure," he explains.

Hospitals are paid based on costs, but they will now be paid based on the APC fee schedule. "The amount that will be paid for a particular CPT code will be grouped with other services," he says.

Number of payment levels cut

The APC system groups services together and pays a present average fee for that group of services, which reduces the total number of payment levels. "The principle is, the payment for a laceration is averaged across all lacerations. For instance, all laceration repairs at the simple or intermediate level are grouped into a single category," says Smith. "So the hospital payment will be the same for a 1-inch laceration as it is for a 5-inch laceration, whether it is a layered closure or not."

2. **Payment rules for physician offices and hospital outpatient services will be standardized.** According to HCFA, the proposed prospective payment system for outpatient services is designed to create a "level playing field" where the same payment methodology is used to reimburse for a service, regardless of where it is performed. However, the same payment rates won't necessarily apply to different settings.

"Implementation of these proposed rules will impose on hospital outpatient services the payment rules that HCFA already applies to physician services," says Smith.

[Editor's note: The complete regulations can be reviewed on the Federal Register Online *(Sept. 8, 1998). Web site: www.nara.gov./fedreg. Information also can be obtained from the American Hospital Association at www.aha.org.]* ■

5 ways the new Medicare rules will change your job

The new Medicare billing rules will cause many changes in your ED's operations, say emergency medicine experts. Here are several things to prepare for:

1. **Nursing services will need to be documented and billed for.**

It is estimated that 50% of payments from Medicare will be linked to nursing procedures, reports **Mason Smith**, MD, FACEP, president and chief executive officer of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. "What is going to catch everybody by surprise in the ED is that nursing services will become a major source of payment," he predicts.

Nursing documentation will drive payment of these services. "It's going to be incumbent on the nursing department to work out how they are going to capture these charges," he says. "Nursing services will need to be recorded so it can be identified they were performed."

Nurses will also need to document current procedural terminology visit levels. "They will need to meet the physician documentation guidelines and will have to do evaluation and management coding just like physicians," he says. "So that means a complete revision of their charge master for assigning visit levels."

2. **An expanded list of services will be necessary.**

"The ED will need to include both services currently charged for by the physician, and an expanded list of services typical for physician offices, such as administration of medication by [intramuscular] injection," he says. "Some of these procedures are going to be bundled, but the majority are not."

Two hundred specific procedure codes will need to be added to cover all of the services that may be performed, he adds. Some of these procedures are performed only by nurses. "Because of that, nurses cannot simply take the physicians charges and use those to determine their charges for services," Smith says. "That will potentially work for visit levels, assuming that the physicians are accurately charging, which may not be the case."

By reviewing the HCFA-proposed regulations published in the Sept. 8, 1998, *Federal Register*, you can learn whether or not your charge master is complete. "Your charge master will be radically different in the future, because it will need to list between 200 and 300 specific charges," he says.

3. **There will be a limitation on the amount of copayments that hospitals can bill for**.

This change could have a major impact on a hospital, depending on its pricing strategy, according to Smith. "If a hospital has had very high prices, then they are going to see a very significant cash reduction. There is a limitation on patient copayment, and that is the part hospitals can bill for immediately after providing a service."

Under current law, 20% of a Medicare patient's bill is charged as a copayment. "Under the new rules, every line item will have a limited copayment. And that copayment will not be billable until after Medicare has told the hospital that it is an approved service, just like they do for physicians," Smith explains. As a result, hospitals will not be able to bill immediately for copayments. "They will be dependent on the turnaround of the Medicare explanation of benefits, so that they know what they are legally allowed to bill," he says.

Under the proposed prospective payment system (PPS), beneficiary copayment eventually will be limited to 20% of the maximum allowable payment from the Medicare program. "The copayment policy includes incentives for hospitals to voluntarily reduce beneficiary copayment toward the 20% copayment objective," he explains.

4. **The administrative burden will increase.**

Hospitals will submit more detailed bills than they have in the past, which will result in a major increase in paperwork, he says. "Maintaining 300 separate charges, as opposed to the usual five or six, is work in itself."

Preparing for the new system will call for the creation of new charge masters for facility services that parallel those for physician services. "This will require redefining and repricing the services provided in the ED," he says.

Hospitals will need to submit the appropriate ambulatory patient classification visit code to describe the services related to the medical visit portion of the ED visit. "Most hospitals have assigned individual patients a single charge for the services provided in the ED," Smith explains.

For example, a hospital may have eight levels of ED care. Level 2 may include a visit and simple suturing of a wound. Level 3 may apply to a sprained ankle requiring an X-ray. "Under the PPS, billing in this fashion will not result in full payment to the hospital. To be paid appropriately under the proposed system, hospitals will have to report ED services following the same coding conventions required for physicians."

Now, the number of ED charges will have to increase to encompass charges that were previously captured by central service and ancillary departments, particularly pharmacy and central supply, Smith explains. The average number of charges per encounter is likely to be about two and one-half, he adds.

EDs must ensure their charge masters identify the items and services that were previously charged by other departments. "For example, a tetanus toxoid immunization injection is often reported as a pharmacy charge," he notes. Under the PPS, the service must be reported by the ED.

5. **Miscoding will have a greater impact.**

Many hospitals have instituted very conservative compliance programs to avoid fraud and abuse allegations. "Those programs have been targeted at the physician services, not at the hospital services," says Smith. "Often, the compliance staff are not well-informed in assigning ED evaluation and management codes and assign very low levels, which are not appropriate."

Currently, those mistakes affect only the physician payment, but they will affect the hospital's payment in the future. "If you don't assign the correct visit level, it will cost the hospital a lot of money," he says. "Since you will be on a fee schedule, you can't make up for it on the cost report, so that old standard tool is no longer available." ■

What should EDs be worried about?

The proposed Medicare billing regulations raise several concerns in emergency medicine.

"The ED will be swept in with other outpatient services. So we need to look at the global picture to see if we are being mistreated," says **Mason Smith**, MD, FACEP, president and chief executive officer of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine. **(See excerpt from the American College of Emergency Physicians' comments on the proposed regulations, p. 91.)**

Consider these eight primary areas of concern for the ED:

1. **Diagnosis vs. symptom-based payment.** The biggest concern is that the Health Care Financing Administration (HCFA) will decide to base payment on patients' eventual diagnoses instead of their presenting symptoms, reports **Charlotte Yeh**, MD,

Prospective payment: How does it work?

Prospective payment will be based on a fee schedule very similar to that applied to physician services, with payment linked to services provided, says **Mason Smith**, MD, FACEP, president and CEO of Lynx Medical Systems, a Bellevue, WA-based consulting firm specializing in coding and reimbursement for emergency medicine.

The major difference between the physician fee schedule and the proposed facility payment fee schedule is that for facility payment. The Health Care Financing Administration (HCFA) has elected to group multiple services into single payment groups instead of establishing a separate payment for every listed code. The payment groups are called ambulatory payment classifications (APCs)

HCFA has created three groups of visit codes for services provided in the ED: APCs 951, 953, and 955. "HCFA has combined the two lowest and two highest levels of service into single groups," Smith notes. The APC groups are defined as:

- APC 951: includes current procedural terminology (CPT) codes 99281 and 99282;
- APC 953: includes only CPT code 99283;
- APC 955: includes CPT codes 99284 and 99285.

This grouping presents two potential problems, argues Smith. "First, separating CPT code 99282 and CPT code 99283 will be problematic because these two visit levels have very similar documentation requirements," he says. "They share the same history and examination requirements: expanded problem-focused history and examination. They are separated only by the complexity of physician decision-making required to manage the case."

Second, combining 99284 and 99285, level four and five, is problematic because of the inherent differences in the two visit levels, Smith says. "Level 5 services often include prolonged evaluation in the ED and may lead to a period of observation. The decision to combine these two levels of service will limit the reimbursement available to hospitals that manage their Medicare patients as outpatients instead of admitting them to the hospital.

This payment structure will provide an incentive for EDs to admit patients quickly rather than try to manage them as outpatients, he says. "Elimination of separate payment for observation will further strengthen the ED's incentive to admit quickly." ■

FACEP, medical director for Medicare policy at the National Heritage Insurance Co. in Hingham, MA.

"If payment is diagnosis-based, it would be very hard to figure out the cost of providing service because people have so many presenting complaints and symptoms," Yeh says.

2. Coding for services.

There are currently five levels of current procedural terminology (CPT) physician billing codes, but it is still unclear whether the existing CPT codes will be used to develop the APCs.

"The APCs should be based on existing CPT definitions, using CPT methodology to base pricing on actual work performed," Yeh emphasizes. The alternative is developing APCs by diagnosis, which would be problematic, she says.

Another possibility is to use existing CPT levels of service plus a critical care code. "That would identify those patients who get critical care services but end up not being admitted, either because they died or were transferred to a new facility," she explains.

3. Reimbursement for observation services.

Medicare is likely to cease reimbursement for ED observation services, says Smith. "Hospitals can continue to provide the service, but it is unlikely that Medicare will provide any financial incentive to the hospital to develop this service," he notes.

This change means that no separate payment will be made for observation services in the ED. "According to the published rules, observation services will be bundled with emergency medicine visits," says Smith. "This will result in the elimination of incremental payment to hospitals for patients placed in observation status after an ED visit."

ACEP wants recognition for ED observational services because they are often a more cost-efficient way of caring for patients. "If that is not recognized by HCFA, then the only option will be to admit patients to the hospital," Yeh says.

4. Fees for medical screening exams.

HCFA is proposing a medical screening fee for evaluations required under the Emergency Medical Treatment and Active Labor (EMTALA). "The concern about that is that the exam is broadly defined as whatever is required to determine the presence or absence of an emergency," she says.

Identifying a single fee may be risky if it translates into a single payment without recognizing the full range of services EDs have to cover, Yeh explains. "The screening exam may include a wide range of services, from simple to complex."

5. Volume disincentives.

If patient volumes increase, the payment schedule may decrease, warns Yeh. "So if they see your volume increasing, you may find yourself penalized for being the safety net for the community. In emergency medicine, we don't have control over volumes, and all you need is one flu epidemic to dramatically increase volumes."

6. Defining ED property.

The regulations address the definition of ED property. "HCFA is defining it to include the driveway and sidewalks. That is basically taking the EMTALA guidelines and extending them even further, which is a concern," she says. "This section is only two paragraphs out of 400 pages, so it is easily overlooked, but it could be very problematic."

The section was included in response to the controversial incident at Chicago's Ravenswood Hospital in May, when ED staff, citing hospital policy, refused to help a 15-year-old gunshot victim lying less than a block from doors of the ED, he says. Police finally dragged the boy inside the hospital, but he soon died.

The ED property definition could cause serious problems for EDs, says **Michael Bishop**, MD, FACEP, vice president of the American College of Emergency Physicians in Dallas. "We in emergency medicine feel we should take care of everybody that comes to the ED. But to use a silly example, what if you had a rural hospital that owned 200 acres and somebody was hunting in the far corner of that property and sprained an ankle? Would the ED be responsible?"

The regulation also defines "the hospital" as anything the hospital owns, which could include a large campus or remote facilities, he says.

7. Competitive issues.

Depending on the percentage of Medicare patients and what the actual payment levels turn out to be, there could be a major impact on EDs in competitive areas. "If HCFA uses a diagnosis-based fee schedule, and one ED is a trauma center and the other is a cardiac center, it could cause major shifts in payments without a change in population," Yeh says.

8. Decreased level of care.

Depending on adequacy of payment and how payment groups are defined, the new rules could cause EDs to provide less care in order to have a higher return. "If fees are not based on how much service you've provided, and are instead based on diagnosis, you might find hospitals trying to attract the better diagnosis cases and doing less care for higher cost," she says. ■

Here are ACEP's main concerns about HCFA rules

The following is an excerpt from the Dallas-based American College of Emergency Physicians' (ACEP) commentary on the Health Care Financing Administration's (HCFA) proposal. The proposed regulations will change outpatient reimbursement for hospitals into a system that uses ambulatory patient classifications (APCs).

✔ "ACEP strongly recommends that HCFA rely exclusively on CPT [current procedural terminology] evaluation and management codes, without diagnosis codes, to define medical visit APCs.

✔ "To improve consistency across sites of service, ACEP believes that hospital outpatient clinics and ED services should be treated similarly to office-based outpatient services. The Medicare fee schedule does not consider diagnosis for practice expense payment in the office or non-hospital sites of service; therefore, neither should diagnosis codes apply to the ED setting.

✔ "ACEP recommends that, for ED services, HCFA establish five visit APCs, in addition to the proposed critical care APC. These new APCs should be based on the five existing CPT definitions for ED evaluation and management levels.

✔ "ACEP supports HCFA's recommendation to utilize critical care as a separate APC that can be assigned to ED patients.

✔ "ACEP supports the concept of establishing a uniform level of payment for lower intensity services so that ED payment is consistent with the payment made for similar services in the outpatient clinic.

"In certain communities, where there is limited access to care, use of the ED for unscheduled urgent visits is, in fact, desirable. Often the ED represents the only source of available care of this type in the community. Recognizing this important safety net role of EDs, without increasing costs, is consistent with HCFA's mission.

✔ "ACEP recommends that HCFA create a separate APC for observation services provided in hospital outpatient settings. ACEP also recommends that hospitals be permitted to bill for observation services in addition to ED or clinic services on the same date.

"Providing an outpatient observation APC would recognize the level of work required for outpatient services, above and beyond other services provided to a particular outpatient. These patients require more management than a traditional outpatient visit, but less than would be involved in an inpatient admission.

✔ "ACEP recommends that HCFA reclassify cardiac and cerebral thrombolysis from status C (inpatient only) to a valid procedure for outpatient services.

"Although the majority of the patients that require this therapy will be admitted to a hospital, many patients will be transferred to another facility for admission. Some patients may also expire after therapy but before admission. Medical necessity for thrombolysis requires immediate treatment. Therefore, the procedure necessarily can and will occur in the outpatient setting (e.g., emergency department) prior to admission or transfer arrangements being made.

✔ "Creation of a unique code for a medical screening examination (MSE) violates the EMTALA regulations. Essentially, the MSE encompasses a full range of services from simple to complex. Therefore, use of existing evaluation and management codes has a number of benefits. These codes are familiar, with known definitions, and reflect the range of MSE services more accurately.

"The regulations do not contain a specific definition of a MSE. This would lead to local carrier/intermediary definitions, which could vary widely around the country. Such a variation in definitions would lead to dramatically non-uniform coverage of such examinations.

✔ "EMTALA expansion should be limited to those hospital entities that hold themselves out to provide emergency services.

"Although ACEP endorses the clarification of the anti-dumping language to include parking lots, sidewalks, and driveways of the hospital campus, we are concerned about how this might be interpreted. The ED staff are obligated to those patients in the ED and should not be required to abandon that setting to provide care for patients in other parts of the campus. Some mechanism must be developed to achieve the stated purpose of providing a MSE without compromising the ongoing care in the ED.

✔ "ACEP strongly urges HCFA to entirely withdraw the behavioral offset adjustment, if not in total, then at least for services provided in the ED.

"Hospitals do not determine, nor can they control, the number of patients, including Medicare patients, who present for treatment to their EDs. A behavioral offset would not address any behavior seen in the ED, and will undermine the critical safety net role that EDs provide to the community.

"EMTALA prohibits the ED from turning any patient away. EMTALA requires that every patient who presents to the ED must receive a complete MSE.

"There are many unpredictable factors, such as endemic infectious disease, severe weather conditions, or even acts of terrorism, that govern use of the ED rather than anything under the hospital's control. Use of a behavior offset would penalize the ED for the vital safety net and access of last resort roles the ED fulfills." ■

Should you switch to template documentation?

Cut time in half and save up to $150,000

Template charting systems are a new approach to documentation, consisting of preprinted sheets for specific chief complaints. Checkboxes and diagrams are marked by the physician, which cuts documentation time in half compared to traditional methods, eliminates transcription costs, and ensures accurate coding.

"There is a definite trend of many EDs switching to this system," says **Louis Graff**, MD, FACEP, FACP, associate chief of emergency medicine at the University of Connecticut School of Medicine in Farmington.

The written chart is obsolete, Graff argues. "It may be cheap, but it cannot meet even the old, let alone the new, HCFA [Health Care Financing Administration] documentation requirements," he says. "The template system is readable, meets documentation requirements, and is quicker since much of the charting can be done at the bedside while interviewing the patient."

Here are some potential benefits of template documentation systems **(see sample, p. 93)**:

• Reduced costs.

The costs are between those of traditional dictation and voice-activated dictation, or approximately $1 to $2.50 per page depending upon the vendor and product, says Graff.

EDs that switch to template charting from dictated transcription can save considerable amounts. "We saved our hospital between $125,000 and $150,000 in transcription fees," reports **Wayne Christiansen,** DO, FACEP, an ED physician at Charlton Medical Center in Fall River, MA.

• Quicker documentation.

Both voice-activated and traditional dictation take between four and six minutes, says Graff. "Template is purported to take half that. There have been no published studies, but the users who have switched from dictation are claiming great time savings," he notes.

Because there may be hundreds of different templates, a well-designed form enables clinicians to learn quickly where specific sections are. "Once they have learned that, when they pick up a template form, they instantly know where to look for a particular item," explains **Randall B. Case**, MD, FACEP, director of emergency medicine systems for Cerner Corp., a supplier of clinical information systems based in Kansas City, MO. "That isn't the case when you are using a free-form paper chart." **(See list of vendors, p. 94.)**

• More accurate coding.

The information needed to qualify for various levels of care is already on the template. "That serves as a mental cue to remind you to ask for certain elements which are necessary for the patient history, or look for certain things on the exam," says Christiansen. "That ensures you qualify for whatever level of care is indicated for the problem."

For example, the diagnosis for a patient with a cold may seem straightforward, but specific questions may reveal additional problems that aren't readily apparent. "For example, you may discover the patient has a sore throat, a rash, or headaches," he says. "When you start doing the physical exam, you find you have moved from just one single body system to several." The diagnosis is substantiated by a more extensive history and physical, and more time is involved, and it may qualify for a higher level, he explains.

However, a recent study showed that gross billing was $29.60 more per patient with template documentation, compared with standard written documentation, due to a higher level of evaluation and coding.[1]

Getting the full picture?

Some experts suggest that template charts fail to provide a full clinical picture of the patient's condition. "The criticism of private attendings who are given template documentation rather than dictation is they cannot tell what is going on with the patient," says Graff. "There is definitely an issue with our non-emergency physician colleagues viewing this as a lower standard of documentation and less helpful to them when they have to follow up with the patient or admit the patient."

• Thorough documentation of rechecks.

At Charlton, the ED group was failing to document rechecks on patients, resulting in lost revenue. "Physicians are notorious for not documenting those rechecks. Physicians were relying on nursing notes to reflect the changes in the patient, but the physician needs to do so also," says Christiansen.

For example, physicians may not document the time spent with a very sick patient with pulmonary edema who requires a lot of time at the bedside and repeated exams. "The template prompts you to write down the time and what the patient looks like during each recheck, and [it] has a specific code for that," he says.

The form improved the group's reimbursement in terms of category justification, including rechecks. "Previously, doctors would look at patients every

Continued on page 94

 Circle positives, check normals, backslash (\) negatives.

33 *Your Hospital Name Here*

EMERGENCY PHYSICIAN RECORD
Chest Pain (5)

TIME SEEN:_____ ROOM:_____ __ *EMS Arrival*

HISTORIAN: __patient __spouse __paramedics_____

__HX / __EXAM LIMITED BY: _____

HPI

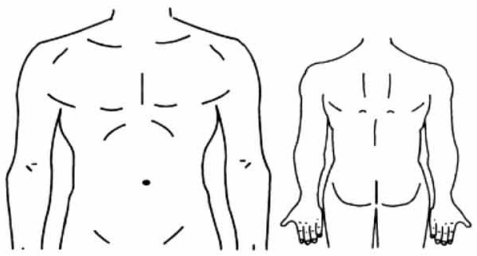
chief complaint: **chest pain / discomfort**

started: _____

time course:
__still present __better __gone now
*lasted*_____.
__resolved on arrival in E.D.
__constant __"waxing & waning"
__intermittent episodes lasting _____
__worse/persistent since _____

quality:
pressure
tightness
indigestion
burning
dull
aching
sharp
stabbing
"pain"
"numbness"
"like prior MI"

Location of pain:



radiation: none diagrammed above _____

associated symptoms:
__nausea __shortness of breath
__vomiting __sweating

worsened by:
change in position
deep breaths / turning
exertion
nothing

relieved by:
sitting up
rest
antacids
nothing
__NTG 1 2 3 _____
patient's own supply
given by paramedics
relief- none / partial / complete / transient
__Oxygen __NRB ___L

onset during:
sleep rest light activity
mod. / heavy exertion
emotional upset
cannot recall

severity:
*maximum: (1-10)*_____
mild moderate severe
when seen in ED: (1-10) _____
gone almost gone mild moderate severe
residual discomfort in arm (L / R)

__Similar symptoms previously_____

__Recently seen/treated by doctor_____

ROS

CHEST-CONST
__fever
__chills
__cough
sputum
__ankle swelling
__calf / leg pain

FEMALE REPRODUCTIVE
LNMP
__vaginal discharge
__abnormal bleeding

NEURO
__headache
__blackouts

EYES-ENT
__blurred vision
__sore throat

GI and GU
__abdominal pain
__black / bloody stools
__problems urinating

SKIN & LYMPH & MS
__skin rash / swelling
__joint pain

☐ all systems neg. except as marked

PAST HISTORY __negative

* = *MI risk factors*

*__high blood pressure
*__diabetes *insulin / oral / diet*
*__high cholesterol
*__heart disease
heart attack (MI)
angina / heart failure
__DVT / PE / risk factors
__other problems

__emphysema
__collapsed lung
__stroke
__peptic ulcer
documented? yes no
__gall stones

Surgeries/Procedures: __none __non-contributory

__cardiac bypass
__cardiac cath
__angioplasty
__thrombolytics
__pacemaker
__tonsillectomy
__cholecystectomy
__appendectomy
__hysterectomy

Medications __none __ASA __NSAID
__acetaminophen __BCP's
__see nurses note

Allergies __NKDA
__see nurses note

SOCIAL HX *smoker_____ *drugs_____
alcohol *(recent / heavy / occasional)* _____

FAMILY HX *CAD (<55yo / >55yo) _____

Source: This is a partial sample of a template charting document from T-System, Emergency Services Consultants, Dallas.

half-hour without thinking of reimbursement for that, but the form reminds them to document everything," he says.

• An immediately available record.

If a patient returns again in a few hours for the same problem, the information about their previous visit is accessible, says Christiansen. "You don't have to wait for it to be transcribed, and the record reflects lab work, which you may not want to repeat again," he explains. "Or the physical exam may have changed since the patient was in. If a patient comes in for the second time with abdominal pain which is now localized to one area, the chart is right there for you."

• More consistent care.

Template forms allow all physicians in an ED group to have a uniform approach during assessment and physical exam. "For example, if a patient presents with a headache, the form tells you to ask about carbon monoxide exposure," notes Christiansen. "That's not something everyone would think to ask, but this way the question is posed."

An ED group can modify a template to produce a consistent standard of care. "The templates are very well-suited to developing a group consensus for complex high-cost treatments such as t-PA," says Case.

• Information that can be shared easily.

With a computerized template documentation system, data can be shared in real time. "This is very significant in the ED, because the information can be shared with the floors instantly," says Case.

• Reduced liability.

Because templates encourage complete documentation, you have better capability to defend yourself against allegations of malpractice, says Case.

• Less ambiguity.

Templates are designed for a patient's specific chief complaint. "Digitalized human photographs on most of the charts take away ambiguity of the actual location of injury/pain," notes **Jeffrey Oyler**, MD, president and chief executive officer of the Atlanta-based Poseidon Group, which developed a template system.

• Compliance with documentation requirements from the Health Care Financing Administration (HCFA).

Many ED groups have switched to template documentation for this reason alone, notes Case. "HCFA has become more and more specific in recent years as to what has to be documented for each level of service," he says. "As a result, the care provider not only has to think about what the patient needs, but also be concerned with what they need to document."

To constitute a valid Level 5 charge, 10 out of 14 body systems must be covered in the physician's review of systems. "If a complex cardiac patient in shock with arrhythmia is being admitted to the cardiac care unit with an acute heart attack, the physician can't just focus on the heart and lungs, because HCFA also requires a review of other systems, such as neurologic, [gastrointestinal], and psychiatric," says Case. "If the clinician fails to do so, the charge will be reduced."

If an invalid charge is found repeatedly, the hospital also could be charged with fraud and abuse, he warns. "You can be cited if you are billing for level 5 services when you didn't document them. Computerized template systems can preaudit the record, so if you only reviewed nine systems, it alerts you."

Selected Template Vendor List

Here is a partial listing of vendors that offer template documentation systems:

- **The Navigator:** a template documentation system designed to meet Medicare requirements. Contact: The Poseidon Group, 79 Poplar St., Suite C, Atlanta, GA 30303.Phone: (404) 261-0401. Fax: (404) 524-7789. E-mail: CscottG8R@aol.com. Web: www.poseidongroup.com.
- **The T-System:** a template charting system with more than 50 documentation tools, including adult and pediatric templates. Contact: Emergency Services Consultants, 4020 McEwen Drive, Suite 281, Dallas, TX 75244-5091. Phone: (972) 503-8899. Fax: (972) 503-8898. Web: www.tsystem.com.
- **PowerNet:** a structured documentation module within the FirstNet Emergency Department Information System. Contact: Heidi Zimmerman, RN, BSN, Cerner Corp., Enterprise Marketing Specialist, 2800 Rockcreek Parkway, Kansas City, MO 64117. Phone: (816) 201-3460. Fax: (816) 201-9460. E-mail: hzimmerman@cerner.com. Web: www.cerner.com.

Following HCFA guidelines

Templates can help physicians comply with HCFA guidelines. Oyler says, "Most physicians focus more on their clinical examination than their writing skills, and thankfully so. Many of the guidelines are so tough to remember that they are missed. In other words, if something isn't documented, then it wasn't done." As a result, reimbursement is decreased, he says.

• Possible future computerized analysis of patient management.

Vendors are currently beta testing computerized template systems that are designed to analyze data, in

addition to documentation. "Each checkbox contains data that can be analyzed on a database," Graff says. "After documentation is completed, physicians can get an analysis of what is the correct code and [evaluation and management] level of service for billing. It also gives the physician suggestions on diagnosis and management issues."

Reference

1. Marill KA, Gauharou ES, Nelson BK, et al. Prospective, randomized trial of template-assisted versus undirected written recording of physician records in the emergency department. *Ann Emerg Med* 1999; 33:500-509. ■

Legislation targets patient rights

Despite ample attention from the media and widespread public support, patient rights legislation still has not passed, reports **John Moorhead**, MD, FACEP, president of the Dallas-based American College of Emergency Physicians (ACEP).

"Patients should be able to access emergency care whenever and wherever they need it," he says. "We urge Congress to pass meaningful patient protection legislation this year."

Partisan fighting has brought efforts to pass such legislation to a standstill, notes **Charlotte Yeh**, MD, FACEP. "It's really a shame to have politics driving the situation rather than patient care needs," she says. "It also reflects the fact that the insurance industry has a huge-dollar war chest that they are drawing on to get support."

Presidential vote affects delay

The 2000 presidential elections also play a role in the delay. "Both parties are trying to lay the ground for the upcoming presidential elections, to blame the other side for why legislation didn't get passed," she says.

However, there has been some legislative activity on the patient rights front. Here are three recent developments:

1. **ACEP strongly advocates passage of legislation consistent with the "prudent layperson" standard, which is now law in 26 states.**

The standard requires managed care plans to cover emergency services without prior authorization and

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *Should you switch to template documentation?*)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *New HCFA rules may cut reimbursement up to 15% for outpatient services* and *Here are ACEP's key concerns*.)
3. Share acquired knowledge of these developments and advances with employees. (See *5 ways the new Medicare rules will change your job.*)
4. Implement managerial procedures suggested by one's peers. (See *Pick your battles: What should EDs worry about?*)

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based on a patient's symptoms, not his or her final diagnosis. It also was enacted by Congress in the Balanced Budget Act of 1997 as the standard for Medicare and Medicaid patients.

The Roukema-Cardin bill, also known as the Access to Emergency Medical Services Act of 1999, would enact federal standards for the "prudent layperson." ACEP could support any bill that either incorporates the "prudent layperson" language from the Roukema-Cardin bill or, at a bare minimum, follows the Balanced Budget Act language, says Yeh. "In the absence of that, it's highly problematic."

2. HR 2045, the Patient Right to Emergency Medical Care Act of 1999, was introduced by Rep. Toomey (R-PA).

However, the bill would not adequately protect the rights of patients, Yeh maintains. "It is basically identical to the House-passed bill in the 105th Congress, which ACEP opposed, she says. "It's worse than the status quo."

The bill does not contain language consistent with the prudent layperson standard. "They use that same terminology, but gutted the true intent," she says. "It is inconsistent with what is already required for Medicare and Medicaid patients."

The language in HR 2045 provides patients with less protection than Congress already provided Medicare and Medicaid patients, Moorhead emphasizes. "The bill is seriously flawed in that it requires patients to meet a new and tougher federal standard for emergency medical coverage," he says. "The language of the bill creates loopholes for endless denials of claims and leaves unclear which services are covered. It also allows managed care plans to make unreasonable charges for cost sharing."

Bill addresses 'prudent layperson'

HR 2045 narrows the prudent layperson standard so patients would be covered only for an initial but undefined "appropriate screening examination."

"For all other services, including potentially life-saving treatments, emergency physicians would have to certify in writing that the patient needed immediate emergency medical care," Yeh says.

Yet the plan would only be required to cover such care if a "prudent emergency medical professional" would agree with the treating physician's judgment.

Those additional bureaucratic processes have the potential to delay timely emergency care, says Moorhead. "Therefore, this legislation would establish new loopholes for the managed care industry to second-guess patients and ED physicians about the delivery of emergency services. Patient in severe pain who make a reasonable decision to seek emergency care would not be fully protected," he explains.

3. An amendment was added to the Patients' Bill of Rights Act (S-326) to protect patients in emergency situations by allowing them to go to the nearest ED without incurring additional costs or copayment charges.

"The Hutchinson-Enzi amendment removes a significant barrier to emergency care," Moore explains. "It states that under the prudent layperson standard, a patient will not incur any higher copayment or liability for seeking emergency services outside their network." ■