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Teamwork and Excel expertise lead to fewer 'on-hold' accounts

Effort targets reasons behind DNFB, OPEX lists

Philadelphia's Presbyterian Medical Center, part of the University of Pennsylvania Health System (UPHS), is dramatically reducing the number of accounts "on hold" in its DNFB and OPEX queues — and freeing up the revenue they represent — with multidisciplinary teamwork and the development of review and monitoring reports on Excel spreadsheets.

The project targets accounts in the "discharge not final billed" and "outpatient exception" categories, which — for a variety of reasons — have not been billed to the patient or the patient's insurance company, says **Anthony M. Bruno**, MPA, MEd, director of patient access and business operations.

During a two-month period from March 7 to May 8, 2003, the number of DNFB accounts was reduced by 18%, representing a dollar amount of $3,818,057; while OPEX accounts were reduced by 2.3%, representing a dollar amount of $1,520,478, or 18.7%, he adds.

OPEX accounts older than 90 days were reduced by 60.8%, Bruno notes, while the dollar amount of those accounts was reduced by 55%, or $1,338,632.

"We have been working to improve our revenue cycle management, and there are a lot of aspects — front to back — that my department and others must get involved in," he says. "One of the things we have been most concerned about on the front end is management of the DNFB and OPEX reports. We wanted to create tools to help us address and monitor both of those pieces."

The challenge was that removing the hold on these accounts requires interventions by a number of departments and a cooperative, collaborative effort to resolve the problems that caused them to be placed on hold in the first place, Bruno says.

There are several reasons accounts might be placed on hold status, explains **Raina Harrell**, manager of access and financial systems. "You can enter all the information and think you did everything you needed

to do, and [the account] will look perfect; but for some reason, the bill doesn't go out the door."

That might be because there was an automatic bill hold, the guarantor information was incorrect, a diagnostic code was not entered, or for any of a number of other reasons, Harrell says. "But if you look only at the front end and the back end, [an account] may look correct."

In addition, Bruno points out, gaining access to the specific accounts that make up the DNFB and OPEX reports was a complex task that required obtaining and cross-checking several reports created by the hospital's computer system, which is a product of Malvern, PA-based SMS (Shared Medical Systems). Once the reports were obtained, he says, they were difficult to read and time-consuming to review.

When they worked together at another health care system, Bruno notes, he and Harrell had experience in creating tools to simplify this process, but with the computer expertise of outside consultants, who helped download the reports from SMS and compile them in a web-based format that provided access to individual account information.

Using in-house resource

Without a budget for outside expertise, Bruno and Harrell drew on in-house resources, assembling a team that included participation from — in addition to Bruno's staff — the director of medical records, the medical assistance coordinator, and a financial analyst from administration.

The team discussed and implemented the following measures:

- developed and created a DNFB and OPEX review and monitoring reports on Excel spreadsheets;
- ensured that the DNFB and OPEX spreadsheet reports provide easy access to specific account information that could be reviewed efficiently and in a timely manner;
- examined root causes of why accounts were on hold on the DNFB and OPEX reports;
- established benchmarks for the DNFB and OPEX by "hold" area of responsibility for accounts on the report;
- established strategies to reduce DNFB and OPEX accounts and dollars;
- created and established an approach that encouraged team members to work collaboratively to reduce those accounts and dollars.

Depending on the reason an account was being held, responsibility was allocated to a particular department, Harrell says. Bills holding for diagnostic information, for example, are the responsibility of medical records. Those with user holds — a manual bill hold put on an account because it is awaiting additional information — go to the business office.

The bill might be awaiting, for example, an authorization number from clinical resource management or from an insurance company, she explains. "The business office can use [the monitoring and review report] to ensure that it is getting timely feedback [on missing information]."

After learning about the report and its purpose, team members were asked to help set expectations for their departments, Harrell says. "For example,

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University of Pennsylvania Health System — Presbyterian Medical Center Recent DNFB and OPEX Reductions Using New System

DNFB	03.07.03	05.08.03	Amount Reduced	Reduction Percentage
Number of accounts	990	808	182	18.4%
Dollar Amounts	$18,192,226	$14,374,169	$3,818,057	21%
OPEX	**03.07.03**	**05.08.03**	**Amount Reduced**	**Reduction Percentage**
Number of accounts	14,124	13,798	326	2.3%
Dollar Amounts	$8,129,472	$6,608,994	$1,520,478	18.7%
OPEX Over 90 Days	**03.07.03**	**05.08.03**	**Amount Reduced**	**Reduction Percentage**
Number of accounts	1,618	633	985	60.8%
Dollar Amounts	$2,432,278	$1,093,646	$1,338,632	55%

Source: University of Pennsylvania Health System — Presbyterian Medical Center, Philadelphia.

we asked the business office for the average amount of time it should take to receive an authorization number so we could remove the user hold, and that amount of time became our benchmark."

"As we get better and the number of accounts is reduced," she adds, "we will lower the benchmark."

The process also has helped identify information systems issues, Harrell notes. "Maybe we've done everything correctly, but [the bill] is sitting out there because the system is not right — like there are two insurances on the front end and only one passes to the back end, or guarantor information or mapping tables are not set up correctly. We wouldn't know it unless we use the tools to look and find those problems."

Key to the project, Bruno notes, has been the participation of **Carrie Moore**, a financial analyst with hospital administration, who worked with Harrell to create the pivot tables. **(See charts above and on p. 88.)** "We really tapped into her Excel and computer expertise," he says.

Those tables, Harrell explains, are an Excel option that will summarize data in a spreadsheet. "They make it possible to report and summarize different information without having to sort the actual data. The user can click on the specific information in the pivot table in which they are interested, and only that data will drop into a new spreadsheet just for them."

"The biggest impact we've made," adds Moore, "is taking canned legacy reports from SMS and

University of Pennsylvania Medical Center — Presbyterian
DNFB Weekly Analysis

	FC	Data # Accounts	$ Amount
Out of State MA	5	2	132,791
Medicaid	A	291	4,979,995
Blue Cross	B	62	802,259
Commercial	C	21	197,368
Managed Care	I	158	3,035,014
USHC	J	31	442,288
Medicare	M	134	3,580,394
Medicaid	P	33	636,194
CBH	R	38	189,831
Healthpass	T	26	278,774
Worker's Comp	W	12	99,262
	Total	**808**	**14,374,168.72**

DNFB Date: 5/8/03

	Within Goal		Beyond Goal		Total	
Reason	**# Accounts**	**$**	**# Accounts**	**$**	**# Accounts**	**$**
Diagnosis	259	$ 3,152,191	183	$ 4,100,400	442	$ 7,252,591
User Hold*	8	$ 84,361	45	$ 718,048	53	$ 802,409
Insurance Holds	2	$ 18,551	2	$ 164,797	4	$ 183,348
Preadmits	116	$ 51,696	2	$ -	118	$ 51,696
FC 'A'	184	$ 3,459,732	107	$ 1,520,263	291	$ 4,979,995

Prior Week

	Within Goal		Beyond Goal		Total	
Reason	**# Accounts**	**$**	**# Accounts**	**$**	**# Accounts**	**$**
Diagnosis	296	$ 5,233,050	153	$ 3,482,658	449	$ 8,717,708
User Hold*	11	$ 67,388	51	$ 992,038	62	$ 1,059,426
Insurance Holds	3	$ 25,113	1	$ 148,471	4	$ 173,584
Preadmits	108	$ 52,893	0	$ -	108	$ 52,893
FC 'A'	175	$ 3,328,648	95	$ 1,342,342	270	$ 4,670,990

*Excludes Financial Class 'A'

Difference

Responsible Department:			Beyond Goal		Total	
	Goal	**Reason**	**# Accounts**	**$**	**# Accounts**	**$**
Medical Records	< 6 Days	Diagnosis	20%	$ 617,742	-2%	$ (1,465,117)
Business Office	< 6 Days	User Hold*	-12%	$ (273,990)	-15%	$ (257,017)
Patient Access	< 4 Days	Insurance Holds	50%	$ 16,326	0%	$ 9,764
Admissions	< 3 Day	Preadmits	100%	$ -	9%	$ (1,197)
Business Office	< 90 Days	FC 'A'	13%	$ 177,921	6%	$ 309,005

*Excludes Financial Class 'A'

Source: University of Pennsylvania Health System — Presbyterian Medical Center, Philadelphia.

parsing them out to get at the actual information and make it more actionable for individuals. In the process, we developed a way to scrub a text file version of the canned reports and arrived at a way to see a summary and see the details."

The summary shows the number of accounts in each category, Bruno notes, and by clicking on that number, the user can see the accounts behind it.

Make everyone aware

All the departments involved — admissions, business office, medical records now can focus on the accounts they need to work, he says. DNFB and OPEX reports are created and distributed each Monday to the work areas responsible for holds, Bruno adds, as well as to the Presbyterian Revenue Cycle Management team.

"Everyone is more aware of the accounts, and more cognizant of what their responsibilities are," says Harrell. "They know what accounts are out there, how they got there, how they can remove them, and what [each department's] role is."

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AMs report few problems with new privacy notice

But opt-out option still causing confusion

Implementation of the Health Insurance Portability and Accountability Act (HIPAA) privacy rule appears to be going surprisingly well, thanks to extensive planning and a public already used to being informed about privacy practices.

That's the consensus of a sampling of access managers who spoke with *Hospital Access Management* about their hospitals' experience with the regulation, which became effective on April 14. Most say any glitches have been minor and have not posed a threat to patient confidentiality.

At Ridgecrest (CA) Regional Hospital, patients are very receptive to signing the Notice of Privacy Practices form, says **Monika Lenz**, CHAA, admitting/communications team leader. "It seems everyone has already been so deluged with these notices from all corners of commerce that our form is a nonissue."

Registrars there have patients sign the form, enter the date they signed in the registration, and then send the original signature to the medical records department, she notes. If the patient goes to a nursing unit, the form is sent there, along with face sheet and consent form, Lenz adds.

If the patient wishes to opt out and not sign the form, she says, registrars check a field in the registration and that patient's information does not appear on certain reports or the clergy census.

The clergy census, meanwhile, has become a more sensitive issue, Lenz adds, and one that has not been resolved completely.

"We have a group of clergy that volunteer to be on call to our patients," she says. "These folks have been used to having the entire census available to them."

In an effort to comply with HIPAA, Lenz notes, the hospital decided to allow clergy of the Christian faith to see only the census for Christian patients, rabbis to see only the names of Jewish patients, and so on. The clergy, however, believe they should be allowed to have a listing of all patients, including those who have no preference listed in the religion field, she says.

"The issue is still pending," Lenz adds, "and we are continuing to give the clergy our full census for now."

For the most part, implementation of the privacy rule is going smoothly at Swedish Covenant Hospital in Chicago, says **Gillian Cappiello**, CHAM, senior director of access services and chief privacy officer. "The biggest issues I hear about are more erring on the side of being overly cautious than potential breaches in confidentiality."

"For example," she adds, "although we are now relatively comfortable with our medical staff having access to all patients, we are still struggling with how to limit access to their office staff, who they rely on to obtain clinical and other protected health information [PHI]."

Concerns that do come up, Cappiello notes, are things such as faxes going astray, as in a recent instance in which the hospital's administration office received faxed PHI with no cover sheet. "Fortunately, the sender's information was programmed to print on the fax, and I called [the sender] — a doctor's office — to explain what had occurred and ask who the intended recipient was."

Even though physician offices are responsible for their own privacy practices, she adds, it gave her an opportunity to remind the office staff why they should always use a fax cover sheet.

On the training and education side, Cappiello says, she does rounds in the departments and nursing units to check for any HIPAA concerns.

"One thing I am finding, with nursing especially, is that each unit is not consistent with how it is handling things," she points out. "Once I have completed rounds, I will be compiling a list of issues that need to be addressed by unit. If another unit has come up with a best practice, this will be shared and implemented on all units, and the unit with the best practice will be recognized and rewarded."

"For example," Cappiello adds, "one unit purchased an enclosed container where specimens for lab pickup are placed; whereas, other units were still using open trays on counters where a label with PHI could be seen by a visitor to the nursing station."

If a concern is common to all units, with no best practice identified, she says, the units will be challenged to come up with one, and the unit with the best idea will be rewarded.

'Opting out' confusing at first

After the initial stress of being worried about making a mistake, of having "to think about 10 times before they say anything," her employees are settling into a routine with HIPAA privacy compliance, says **Lisa Marie Freiberg**, team

leader for admitting at the Lake Hospital System in Painsville, OH.

There was some confusion at first, she notes, with the process by which patients opt out of being included in the facility directory. The way the question was put in the hospital's computer system, Star Navigator, staff had to think about whether the answer should be yes or no, if a patient did not want to be listed, Freiberg explains.

In the computer system, the answer was "yes" if the choice was to opt out. On the consent form, the question was phrased so that "no" was the right answer, she notes. "Once they adjusted to that, everything was fine."

Those who do opt out are given a form explaining what their choice means, Freiberg says, and social services and utilization review personnel follow up with patients to make sure they understand.

Encounters with irate family members who — after being unable to get access to the room — say the patient misunderstood also are dwindling, she notes. "Things are settling down. It's just taking the time to explain to patients."

At Davis Memorial Hospital in Elkins, WV, most of the hassle associated with the privacy rule implementation also has had to do with the opt-out provision, says **Pattie Weese**, patient access supervisor.

"A number of people will call and say, 'Do you have so-and-so there?' and we explain that due to federal privacy rules, we can neither confirm nor deny that person's presence in the hospital. The caller will often persist, she adds, saying, 'I *know* they're there.'"

In many cases, Weese says, those calls come to the emergency department and are from people who have seen an ambulance on their street or witnessed an accident and want to know who might have been taken to the hospital.

To minimize misunderstandings, she notes, the hospital gives each patient not only the notice of privacy, but also a separate sheet that summarizes the main points. In addition, Weese says, the director of corporate compliance put together another handout designed to answer patients' HIPAA-related questions.

To ensure compliance, Davis Memorial's computer system was changed so that a census prints out every two hours, containing only the names of those who have said it's OK to include them, she adds.

So far, Weese says, there has been only one patient at the small community hospital who chose not to be included in the list — and that was after the person had been admitted.

One hospital in the area has chosen to take absolutely no chances with privacy rule compliance, she adds. Even in the case of a patient who has not opted out of being included in the directory, Weese explains, that facility won't let callers get past the switchboard unless they know the patient's room number.

Planning and prep pay off

At Providence Health System in Portland, OR, extensive advance preparation — including training front desk employees at facilities throughout the state — helped ensure a seamless privacy rule implementation, notes **Barbara Wegner**, CHAM, director of regional access services.

"We did work on developing and rolling out the new process for at least a year before the effective date," Wegner adds. "I believe all our planning and training paid off, because we have not really had problems when you consider how big our health system is and that all patients need to receive this privacy notice on admission."

A year's worth of planning and preparation — along with the training and oversight provided by the organization's privacy officer — also was the key to a successful transition at the University of Arkansas Medical System (UAMS) in Little Rock, says **Holly Hiryak**, RN, CHAM, director of admissions for the University Hospital.

"Overall, it's gone pretty darn well," adds Hiryak, who also credits work by the information systems (IS) department, which wrote reports allowing immediate monitoring of what was populating the computer system in regard to the privacy notice distribution.

"If we saw something that was not right, we were able to immediately get back to the individual and educate," she says.

The system had been set up so that employees could indicate that the privacy notice was provided when the patient was on site receiving care or that a telephone encounter had resulted in a mail request being made, Hiryak explains.

Because HIPAA specifies that the notice be delivered at the time of the first service provided to the patient after the rule's effective date, she says, in many cases that affects patients calling UAMS for medical advice or to have a prescription refilled.

"We have a huge facility here and a lot of patients calling in, so we had to have a mechanism

for getting the notice out to them," Hiryak says. "[What happens is] we flag the system with a mail request, and at midnight, the system goes back and looks at the fields with 'MR' [mail request] and generates a letter that includes a [privacy] form and an acknowledgement."

Once the letter has been sent, the designation changes to "notice mailed," she adds.

The report designed by IS reads what is in the privacy field, Hiryak notes. If anything other than "notice provided" or "notice mailed" is in the field, employees have to ask the patient about the privacy notice.

Because the privacy field is required, the business office — which sometimes needs to update an account when there is no patient care or contact — had to be given a code to use in the field, she says.

Since patients often come onto the hospital campus and have two or three appointments, the system is set up so that they are asked about the privacy notice only once, Hiryak adds. The privacy field is populated in real time so that the employee handling the patient's second encounter knows he or she has already been given the notice.

As for patient reaction to the additional paperwork associated with the privacy notice, "we really didn't hear too much," she says. "They're getting [privacy information] so many other places that they're used to it. The banks really helped pave the way for us. By the time hospitals came on board, we were just one more group."

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Quick hits and long-term solutions for collections

Upfront financial clearance part of strategy

Health care organizations aware of their need for systemic change but short on the capital required increasingly are taking a two-pronged approach: Make some quick revenue-producing hits first, and then implement the longer-term solutions.

That's just one of the strategies in place at Parkland Health and Hospital System in Dallas, a publicly funded teaching facility with 800-plus beds and a large unfunded patient population, says **Laura Fawcett**, a Detroit-based manager for the consulting firm Cap Gemini Ernst & Young.

"We're starting by trying to make process changes, which are then followed by 'system enablers' to get the next level of value," Fawcett adds.

At Parkland, she explains, the focus is on two things: increasing collections at the time of service, which can provide a financial quick hit, and reducing payer denials, a longer-term value.

In other cases, Fawcett notes, the patient access strategy might be to target unbilled reduction, or accounts in the discharged-not-final-billed category. **(See this month's cover story.)** Some organizations put a hold on accounts pending insurance verification or other information, thus delaying billing and slowing down the revenue cycle, she says. "There can be a large backlog."

"Others don't hold anything," she points out. "That's not necessarily good, if it goes to the wrong payer or the wrong place and you have to resubmit, or if you should have had authorization."

"With [upfront] collection," Fawcett says, "you start seeing cash immediately, and it's a recurring benefit." Although Parkland already does some time-of-service collection, albeit with a lot of variation by service, "you'd be surprised at how many organizations we go into that don't collect any money.

"Part of the challenge is a culture in which the perception is that care is free," Fawcett says. "Even patients who have a copay or other financial responsibility are not asked to pay because of that culture." For that reason, she adds, training will center on managing customer expectation.

Through advertisements in the local newspaper, press releases, and communications with staff in medical offices, Fawcett notes, "we're trying to create the awareness in the community that this [collection effort] is going to occur."

The ads, she says, will include the answers to questions commonly asked about the process, such as, "What should I expect in terms of [the amount

of] money to bring?" or "If I have an emergent condition, can I still be treated [without payment]?"

The answer to the last question, of course, is yes, Fawcett adds, noting that information also will be provided, for example, on the cost of a typical office visit, as well as why the health system is taking such an action.

Starting at scheduling

At Parkland, Fawcett explains, a big piece of the initiative is to put the collection process in motion at the time of scheduling — well before the patient is standing in front of a registrar being asked to pay for a service that already has been given.

To channel patients as needed, key data will be gathered during scheduling, including insurance verification and authorization information, she says. "If a patient needs a referral, for example, the person will not be scheduled at that point, but will be directed to a case manager, who will try to ensure that the referral is in place. Then the patient will be scheduled."

"We're trying to make sure we focus on getting the patient financially cleared as soon as possible," Fawcett adds, by addressing two issues: Does the patient have insurance and, if so, how does the hospital communicate with them early about copays or deductibles?

For patients without insurance, she says, the focus will be on matching them with financial counselors early in the process to pursue coverage through Medicaid or another program. "Up to now," Fawcett adds, "there has been no screening up front to make sure the patient is channeled appropriately. The patient is here and is assigned to a counselor, but if the person doesn't qualify or should be in another county, it's already too late. The opportunity lies in getting funneled prior to service."

At Parkland, where registration is decentralized at present — with a long-term goal of centralizing the process — gathering of the mandatory, upfront data will be done in some areas by clinicians and in others by clerical employees, she says.

"In the short term, we're keeping everyone where they are, and identifying the tools and processes to collect that information," Fawcett adds. "[Employees will obtain] the name, address, medical record number, insurance information — including authorization and referral — and will make sure they have a telephone number for the patient."

In the past, she says, information obtained up front likely would have included the person's name, the date and the reason for the visit, but none of the financial information.

As training for the new process got under way in early July, Fawcett notes, the concern among managers was the time that would be required to gather the data and "how to fit that into the work [schedule]."

Another piece of the puzzle — as well as a catch phrase that is gaining momentum among proactive access departments — is a "deny/delay" policy, which calls for financial clearance up front, she says. "If you're not able to get the patient the appropriate authorization or referral, and the case is non-emergent, you wait and reschedule."

Ideally, this step takes place while the patient is on the phone to schedule the appointment, Fawcett says, but it could happen in person. If it's the latter scenario, she explains, the registrar would say something such as, "You need XYZ to be financially cleared for this service," and would offer the patient a couple of choices: "We can reschedule you at a time when you have that [clearance] or provide the service and you sign a waiver indicating you might be financially responsible."

The key to long-term success in a project such as Parkland's is "being committed to sustaining the change," she points out. "What I've seen with some organizations is that they start the process, but after a few months, the enthusiasm dies down. What we do to try to maintain it is to put measurements in place. What are we collecting per area? How does it measure up to our goals?"

Everyone knows the measures are there and expects reports on how it's going, she adds. "It's just staying committed to that. Continue training and continue to reinforce with the people on the front lines."

[Editor's note: Look for a progress report on the process change under way at Parkland Health and Hospital System in a future issue of Hospital Access Management.] ■

JCAHO standard to address crowded EDs

Board to look at field review, then decide

Access managers with responsibility for emergency department (ED) registration will want to be aware of the proposed new ED overcrowding standard from the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO) that could become effective in early 2004.

The field review for the standard ended in June, notes **Char Hill**, JCAHO media relations manager. "The draft standard will be reviewed by JCAHO board members. They will consider comments from the field review before they take final action to approve, not approve, or approve a modified version of the standard for implementation."

The draft standard specifies that "leaders develop and implement plans to identify and mitigate situations that result in ED overcrowding."

The rationale for the standard is as follows:

"Patients in overcrowded EDs are at high risk of experiencing treatment delays or inadequate care. Because this patient population is particularly vulnerable to the effects of overcrowding, it is incumbent on hospital leadership to engage in the level and scope of planning needed to prevent overcrowding when possible, and to minimize its impact when it is unavoidable.

"Throughout the country," the rationale continues, "many causes interact to create overcrowded ED conditions."

Those causes include:

- increased scarcity of available inpatient and long-term care beds and alternate care settings;
- increased competition for services within the organization, thus intensifying overall demand for ancillary services and increasing service response time;
- shortage of nurses and other clinical personnel;
- decreased number of EDs;
- saturation of the primary care network for both insured and uninsured patients.

Elements of Performance for the standard include the following action points:

- engaging in planning that assesses the scope and impact of ED overcrowding and seeks to resolve identified issues;
- planning encompasses the delivery of care to patients who must be placed in temporary bed locations. These temporary locations must be outside the ED and in an appropriate patient care area;
- planning includes coordination with community resources — for example, long-term care facilities, home health agencies, and other hospitals — for the purpose of expediting discharges from the ED. Would the ED benefit from a social worker?
- measuring specific performance indicators that monitor the capacity of support services and patient care and treatment areas that receive ED patients;
- integrating the organization's handling of ED overcrowding into organizationwide performance improvement activities;
- developing performance measures that monitor the effectiveness of the plan's implementation;
- including methods to minimize diversion through coordination with community resources such as emergency medicine services, air ambulances, or fire departments. ■

EMTALA Q & A

How much is too much talk about wait time?

Concern's a valid one, expert says

[Editor's note: This column runs occasionally in Hospital Access Management *and addresses questions regarding the Emergency Medical Treatment and Labor Act (EMTALA).]*

Question: If a triage nurse sees a patient and performs vital signs, then asks the patient to take a seat, is the nurse able to tell the patient how long the expected wait might be? In our emergency department (ED), sometimes the wait for less acute patients is several hours. We do not want patients to leave without being seen or defer them away, but patients get very upset when they have to wait a long time and they were not informed of the wait time up front. What can the triage nurse do to communicate wait times and still comply with EMTALA?

Answer: You have every reason to be concerned, according to **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk management liaison at St. Mary Medical Center in Long Beach, CA.

"We have all heard statements by enforcement officials that anything that discourages a patient from receiving a medical screening examination may be considered a potential EMTALA violation," he says. "That said, there are steps that can be taken to minimize the risk."

It goes without saying that emergent patients must be seen immediately and urgent patients as

soon as space becomes available, adds Lawrence. Of the remaining nonurgent patients in the waiting room, he says that first and foremost, everyone must "be in the same boat.

"There can be no perception of preferential treatment because of ability to pay, race, age, gender, or any other identifying characteristic," he stresses.

The waiting time can be estimated and told to the patient without violating EMTALA, says Lawrence. He suggests saying something such as, "It looks like the waiting time will be two hours, but we're trying to move patients through as quickly as possible."

Undoubtedly, this will cause some patients to leave, but that is their right, he adds. "EMTALA allows for patients to withdraw their request for a medical screening examination," Lawrence explains.

All EDs should have a form for the patients to sign should they intend to do so, says Lawrence. "The form should make it clear that the ED remains ready to see patients if they change their minds," he says. Consider this wording, Lawrence suggests:

"I recognize that under federal and state law, I have the right to a medical screening examination and stabilizing treatment for any emergency condition found. I hereby withdraw any request for such an examination and/or treatment for myself or for _____ (relation) and hereby release the hospital from any obligations it has under the law to provide such examination and/or treatment."

Another important point is that patients in the waiting area should be re-evaluated periodically to be certain they haven't deteriorated from nonurgent to a more urgent category, says Lawrence.

"From a customer service point of view, this additional contact is important," he says. "It also allows the triage nurse to keep the patient updated as to the ability to find a place for treatment in the ED proper."

However, Lawrence says that the ED has a more serious concern than just EMTALA. "If routine waits at a private facility are as long as is stated, a serious overhaul in the way business is being done is in order," he says. "A task force to see why throughput times are so long is a must."

You need to determine whether the problem is admitted patients taking up space in the ED, long turnaround times for laboratory and ancillary services, lack of physical space or personnel, or all of these, Lawrence says.

"A supportive administration should address these concerns," he emphasizes. "The possibility of EMTALA fines would be a gentle reminder that the problem can't be ignored," he adds.

[For more information about EMTALA, contact:

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NEWS BRIEFS

OIG's EMTALA fines continue downward trend

Fines for violations of the Emergency Medical Treatment and Labor Act (EMTALA) were down for the first half of the Office of the Inspector General's (OIG) fiscal year, with only $314,000 in fines collected from 10 hospitals from Oct. 1, 2002, to March 21, 2003, according to a recent report from **Stephen Frew**, JD, a longtime specialist in EMTALA compliance.

The OIG only reports closed files, says Frew, a web site publisher (www.medlaw.com) and risk management consultant for Physicians Insurance Co. of Wisconsin in Madison. The amount is much lower than in previous years, when fines exceeded $2 million in a single year, he points out, and is consistent with a declining trend since 2000.

Examples of fines listed and the associated violations include the following:

• $30,000 — Discharge of a head injury patient in New Jersey who was later found unresponsive and taken to another facility, where surgery was performed.

• $35,000 — Failure by a California hospital to provide necessary care for a ruptured appendix based on the patient's financial status.

• $17,000 — Failure by a South Carolina hospital to provide treatment to a woman in labor, who was transferred to another facility.

• $120,000 — Failure by a Florida facility that had a psychiatric assessment center to provide

appropriate assessment and stabilizing care/appropriate transfer to mental health patients.

Frew points out that OIG civil fines are less of a burden on hospitals than the stress and expense associated with the citation and plan of correction. ▼

HFMA issues status report on billing project

Hospitals and other health care providers can promote patient-friendly billing in a variety of ways, from reviewing their organization's billing process to signing up to receive an electronic newsletter from the Healthcare Financial Management Association's (HFMA) Patient-Friendly Billing project.

Those are among the suggestions in a recent report summarizing the project, which was launched in 2001 to promote clear, concise, correct, and patient-friendly billing and financial communications. The report also includes a sample patient letter for use in describing the billing process, a sample hospital patient bill, sample patient glossary terms, and a flowchart showing desirable financial communications from the patient's perspective.

To date, about 1,000 hospitals and health systems have signed on to the project's philosophy, according to HFMA. The American Hospital Association is a partner in the project. The report can be found at www.patientfriendlybilling.org. ▼

JCAHO hospital standards reduced to 225 from 508

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has slashed the number of standards in the 2004 hospital accreditation program from 508 to 225 as part of the agency's "Shared Visions, New Pathways" initiative.

Agency officials have said the initiative is intended to streamline standards and focus the JCAHO survey on operations and systems that directly affect patient safety and quality. **(See "Cancel the triennial 'stage play': JCAHO has a new survey process," on the cover of the June issue of *Hospital Access Management*.)**

The requirements for 2004 essentially are the same, officials say, but they note that some "elements of performance" that existed in one accreditation manual may now be applicable across all manuals. In addition, the new format integrates the assessment, care, education, and continuum of care chapters into a single chapter.

Health care personnel may review the new standards, along with a comparison to the current standards, by visiting www.jcaho.org and clicking on "2004 Pre-Publication Standards Now Available." ▼

Survey: Providers ready for October HIPAA deadline

Some 96% of Medicare Part A providers expect to be compliant with the Health Insurance Portability and Accountability Act electronic transactions standards and code sets by the Oct. 16 deadline, according to a recent report from the Department of Health and Human Services Office of Inspector General.

The report indicates that 92% of Part A providers are developing an implementation schedule to meet the deadline, and half are developing contingency plans in the event their systems are not fully compliant by the deadline.

A comprehensive national system is needed, however, to prevent payment disruptions in case processing failures occur, says **Lawrence Hughes**, regulatory counsel and director of member relations for the American Hospital Association.

To see the report, based on the results of a mail survey conducted between Nov. 26, 2002, and March 24, 2003, go to: www.oig.hhs.gov. ▼

COMING IN FUTURE MONTHS

- Tips on handling ABNs
- Is reimbursement on the way for illegal alien care?
- Revamping outpatient registration
- ED collection case studies

Prompt-pay legislation signed by Texas governor

Texas has joined the list of states that have passed legislation designed to ensure hospitals and physicians are paid promptly and appropriately by health plans.

Senate Bill 418, signed in late June by Gov. Rick Perry, establishes a payment time frame of 30 days for claims filed electronically and 45 days for paper claims.

The legislation defines a clean claim, preauthorization, and verification. It prohibits health plans from denying or reducing payment once a preauthorization or verification has been issued unless the provider materially misrepresented the facts or did not perform the service.

The bill also requires verification to be valid for at least 30 days, and health plans to provide a specific reason for failing to verify eligibility or coverage. It specifies that health plans have personnel available during weekday, weekend, and holiday hours to provide verification and preauthorization, and removes coordination of payment responsibilities from the provider and places them on the payer. ▼

Hospitals doing good job, say majority of Americans

Nearly three-quarters (73%) of American adults think hospitals do a good job of serving consumers, according to the latest annual Harris Poll ranking 15 industries for customer service.

The same percentage of Americans said hospitals served consumers well in last year's poll, while health insurers saw a sharp drop in their standing this year.

Only 40% and 30% of Americans said health insurers and managed care companies served their customers well, down from 51% and 33% in 2002, respectively.

Pharmaceutical companies also saw a 10-point slide in their score, from 59% to 49%. The poll surveyed 1,010 adults by telephone between April 10 and April 15. More information is available at www.harrisinteractive.com.

In another recent customer satisfaction poll, by J.D. Power and Associates, hospitals outscored eight other industries. In a survey of 2,350 randomly selected patients recently discharged from general acute care hospitals, three out of four patients who stayed in the hospital at least one night expressed satisfaction with their hospital stay.

Nearly a third (32%) were "delighted" with their overall hospital experience, rating their stay a 10 on a 10-point scale. That's the largest proportion of highly satisfied customer among nine service industries the company surveys: auto insurance (28%), residential electric utilities (27%), home insurance (25%), hotel (16%), Internet service provider (15%), home mortgage (15%), managed care (14%), and telecommunication (12%).

For more information, go to www.jdpower.com. ■