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Hospital slashes medical necessity write-offs with software and training

'We had a phenomenal turnaround in less than a year'

With the help of some user-friendly software and a comprehensive staff training initiative, Parrish Medical Center in Titusville, FL, has dramatically reduced its medical necessity write-offs while improving customer service.

"Our Medicare fiscal intermediary is a very stringent one," says **Christine Rich**, MHA, business director, "with a ton of local medical review policy [LMRP], for which we need to make sure we're meeting the [medical necessity] criteria."

However, registrars, faced with a complicated, inconvenient process for determining if a procedure met medical necessity and then informing patients that it might not be covered by Medicare, often skipped the step altogether, adds **Linda Lilleboe**, RN, MSN, business office manager.

"They had [medical necessity] software up front," notes Rich, "but to use it, they had to leave the registration module and go to another module. If the [physician order] didn't have an ICD-9 code or CPT code — if it was just a narrative — they had to go to a book and look up, for example, 'CBC,' and then look up 'anemia,' and hopefully choose the correct code. They also relied on the coding department for help, which caused a strain on their resources."

If, after all that, registrars found that a procedure was not covered by Medicare, they had to inform the patient, and later the ordering physician, that the scheduled test didn't meet medical necessity, she says. Patients had to be asked to sign an advance beneficiary notice (ABN), indicating they knew the procedure might not be covered and that they'd be responsible for payment.

"They were not prepared for the answer the patient might give," Rich adds. "The patient might say, 'I still want the test; how much is it?' and the registrar didn't know, so there was a whole set of phone calls."

Meanwhile, registrars also were dealing with a room full of waiting patients, Lilleboe says, and getting constant reminders on the need to reduce wait times. "It was easier not to get it signed."

With ABNs not being consistently offered to — or signed by — patients whose procedures were not covered, Rich explains, the hospital found itself writing off the cost of an excessive number of outpatient procedures.

Part of the problem, Lilleboe points out, was that registrars didn't fully understand the significance of what they were being asked to do.

"They had no support," she says. "They didn't understand the bigger picture, the amount of money the hospital had to write off. Even if they had a signed ABN, if the codes were not an exact match to what we billed, the account still had to be written off."

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The mission, therefore, had to be "a whole new re-education of staff," Lilleboe says, making sure they "understood these things are not negotiable." The message to employees was, she adds, "We will give you the tools to do it, but it must be done."

As a result of that effort, which took place between October 2002 and September 2003, the hospital reduced by about 75% the amount of outpatient Medicare procedures that had to be written off due to lack of medical necessity and lack of proper documentation, Lilleboe says. "We had a phenomenal turnaround in less than a year."

Registrars get reminder

Key to that turnaround, Rich and Lilleboe say, has been new medical necessity software that not only is far superior to what the hospital used previously, but also clearly better than several other products they either had experience with or checked out while deciding what to buy. Some of the others, Rich notes, were so complicated, registrars had to just print out the information and send it to the coding department for interpretation.

One of the biggest advantages of the new software is the ability to customize its dictionary to fit the hospital's specific needs, Lilleboe says. For example, a patient might come in with an order for a carotid Doppler study, she adds. "If they didn't know the CPT code or that this procedure was also known as an 'extracranial study,' they would never find it. To expect the registrar to remember all that was not realistic."

"At the beginning [of implementing the software], we would contact the coding department, get the code, fill out the LMRP Customized Procedure form, and say, 'This is the common name of the study, and this is the CPT code,'" Lilleboe explains. "We would customize the software dictionary so registrars could just pull up what Parrish Medical Center had and go to it. Diagnosis clarification was also done using this form."

In the past, she says, registrars might be handling a physician's order for a stress test, and there might be five or six codes attached to that procedure. "They would pull up the stress test and do one code, but miss several others."

To remedy that, Lilleboe adds, "we took the physician order sheet and customized the software to match the codes."

Another convenience of the new system, Rich

Sample Medical Necessity Script

Steps to follow if Medical Necessity has not been met:

- Advise the patient:

"***This/These procedures did not meet medical necessity based on the diagnosis given.*"**
If the patient (pt) has concerns advise him or her to contact their ordering physician. You may contact the physician office, if requested by the patient, for any additional DXs at the time of service.

Pt refuses to sign ABN but demands to have the test:

- Register the patient.
- Document the refusal in the ABN status.
- ABN must be witnessed by 2 associates.
- Enter condition code "20" on page 4.

Pt refuses to sign ABN and refuses test:

- Register the patient.
- Do not need consent signed.
- Document that patient left without having test done.
- Contact physician to notify him or her that the patient did not have test ordered and the pt was advised to discuss with the physician.

Pt signs ABN and has test:

- Register the patient.
- Have patient sign ABN.
- Enter condition code "20" on page 4.
- Attach ABN to Medical Record paperwork.

Pt signs ABN and refuses test:

- Register the patient.
- Patient signs ABN.
- Document patient left without having test done.
- Contact physician to notify them that the patient did not have test ordered and the pt was advised to discuss with the physician.

Source: Parrish Medical Center, Titusville, FL.

says, is that registrars automatically are prompted at the end of a Medicare patient's registration with the question, "Enter/Edit CPT and ICD-9 codes?"

"That question is attached to outpatient registrations with the financial class of Medicare, so it's a no-brainer for the registration staff; it just pops up," Lilleboe adds. "If the patient had commercial insurance, [the question] doesn't come up." With the old software, she notes, registrars got in the habit of bypassing the reminder because it appeared with every registration.

To facilitate the transition to the new software, Lilleboe says, the business office trainer scheduled one-on-one sessions with registrars. "She would go through the process, train them on the software, and then audit them to see how they were doing."

A little more than a year later, she notes, the trainer continues to get weekly requests from staff to update the dictionary. "A strange test will turn up, and the trainer gets the information and inputs it into the software dictionary. We remain very current since updates are sent consistently to our IS department. They do the update, and the business office trainer spot-checks to make sure everything works."

Audits are done every month, and LMRP write-offs continue to be monitored, Rich says. "There's been a real benefit. We still have issues, but we can go back and research if there are problems with a certain code and we can make changes."

Information is put into a spreadsheet so it can be sorted by registration type, and then by CPT code, Lilleboe notes. That's how staff noticed that a high number of electrocardiograms (EKGs) were

not meeting medical necessity criteria, she adds.

"We traced it back and found there was a standing order by a physician that said, 'Do these tests regardless,'" Lilleboe says. "It was probably a standard practice to do an EKG for every man over 45."

Such occurrences are discussed at a monthly LMRP/denial meeting, attended by representatives from health information services, the emergency department, registration, and the business office, she says.

One of the most positive things the audits have revealed, Lilleboe adds, is "we never found one outpatient procedure that a registrar didn't run through the system. We couldn't have said that a year ago."

'Our goal is to move forward'

Good customer service was at the top of the agenda during the implementation of the new process, Lilleboe and Rich emphasize. "We want the registrars to be first and foremost patient advocates," Lilleboe adds.

With that in mind, she says, "upfront" determination of medical necessity means at the point of registration, not — as is the case at some facilities — when the patient is in a dressing room getting ready for the procedure.

To make the process even more seamless for the patient, Rich notes, there is an effort under way to get physicians to fax over more orders in advance, so they can be checked for medical necessity at the time of scheduling.

Despite the vast improvement of the current process, she says, it does take up time during registration and can be inconvenient for the patient. "Our belief is the sooner we do it prior to the time of service, the happier everyone will be. Our goal is to move forward."

Ensuring clear communication with patients has been paramount, Rich says. "It's an uncomfortable situation. Patients feel like you're saying to them, 'Your physician shouldn't have ordered this test,' but you're really saying, 'This procedure did not meet medical necessity based on the diagnosis given.'"

To help them become more comfortable talking with patients about medical necessity — and to make sure the proper message is getting across — registrars were given cards containing "scripts" to use in various situations, depending on the patient's reaction to the information, she adds. **(See sample scripts, p. 3.)**

"Any time we want staff to give a consistent message," Rich notes, "we script it and give them a laminated card."

Despite the best of intentions and procedures, patients sometimes will complain, she says. "However, we remain consistent and always encourage the patient to contact the ordering physician to discuss any issues. We also notify the physician's office with an explanation if we are unable to complete the order."

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Doing two access jobs fills need for challenge

ED supervisor also department trainer

When **Tara Tinsley**, CHAM, decided she needed an additional challenge in her role as access supervisor in the emergency department (ED) at Children's Health System in Birmingham, AL, she didn't have just an occasional extra project in mind.

Instead, when the access director asked her what she'd like to do, Tinsley opted to take on the task of access department trainer, revamping the position into a proactive, hands-on job far different from the way it had been done in the past.

The need was there, she explains, because the previous trainer's position had been eliminated in a cost-cutting move. "We lost one of our management staff, so the trainer became the supervisor of an area."

Access employees needed a neutral person, apart from their supervisor, to perform the training function, Tinsley contended. "I'm a sponge. I like to build my knowledge and tend to absorb and try to learn as much as possible. At the time I had the least number of employees of any supervisor, so it seemed appropriate."

Tinsley was given a little extra compensation,

Access Training Flyer

Effective Monday, Nov. 24, 2003, you will have to go into the Insurance Plan Data Screen to reactivate (Z) a suspended (X) plan. Please note the information below regarding these changes.

Within the revised pathway:

1. On the Insurance Review Screen, all values will be output only. Basically, you will only be able to view information on this screen and add an additional plan code.
2. If a plan has been rejected (X) and you want to verify the rejected plan, you must choose the correct PF key to revise the plan. The PF key will take you to the Plan Data Screen. If you try to put a Y in the verify flag field, you will receive the following error message**: E110494: YOU CANNOT VERIFY A REJECTED PLAN. YOU MUST ENTER A Z.**
3. You must use the Z to verify the rejected plan. This screen will allow you to enter the Z and continue through the subscriber screen.
4. When you return to the Insurance Review Screen, you will see the Z in the verify indicator field.

Please note: The fields in the regular pathway will also be output only. You will still be forced to go through all the insurance screens. However, if you return to the insurance screens from another screen in the pathway, there will be PF keys to revise the plans.

Please report any problems with this new process to the help desk.

Source: Children's Health System, Birmingham, AL.

she adds, and "free rein to develop the position as I saw fit."

The result has been an ambitious agenda of providing on-call, one-on-one training, re-engineering the on-line insurance verification process, and standardizing a quality assurance (QA) process for the department, she notes. In addition, Tinsley issues regular communiqués to staff that she titled "Something New" and "Vital Reminder."

While the previous trainer had focused on distributing training materials to staff and writing policies and procedures, she notes, Tinsley had a different vision of the position.

"If an employee's QA scores fall below a certain point, I work with the person's supervisor to identify her weaknesses, where she needs help, and then I sit with that employee," Tinsley says. "I keep the lines of communication open, and give them one person they know they can come to."

"Not that I receive a training call every day, but I do have an open-door policy," she adds. "Employees don't have to go through their supervisors to get to me. They can page me, call me, or e-mail me when they need help. They might be right in the middle of a registration and something unusual occurs, so they page me."

Tinsley lets employees know they can call her for help even when she is not at work, and with the access department open 24-7, she says, "I do get called after hours."

Every month to six weeks, Tinsley says, she produces the one-page flyer called *Vital Reminder.* **(See sample flyer, above.)** "It encompasses key training opportunities we see with our staff," she adds, "like continued improvement with customer service."

The flyer also might inform staff of problems she has noticed with customer accounts, such as an incorrect insurance entry, Tinsley says. "I like to say I do one every month, but it may be six weeks. It is e-mailed to all [hospital] access personnel, as well as to nonaccess areas — such as outlying clinics — that use our computer system to register patients."

The other publication, *Something New,* is used to announce new policies or procedures, or changes that are to be implemented at a certain point, she notes. "For example, some changes to the way our staff enter insurance go into effect on Monday. Rather than let them come to work that day and experience this live, I created a training sheet that tells them what the changes are, how they will impact [employees], and gives a step-by-step process for working through the change."

Tinsley's biggest training effort, she says, has

Area-specific policy packets easier to digest

About a year ago, **Tara Tinsley**, CHAM, access supervisor and department trainer for Children's Health System in Birmingham, AL, says she came up with the idea of having separate policies and procedures for the various access areas.

In the past, says Tinsley, who conducts the department's employee orientations, new access personnel were given a huge stack of policies to wade through. "Ninety percent of them never read the policies," she adds. "It was just too much."

"Now, what they get is a packet of policies pertaining only to their areas and their jobs," Tinsley notes. "Giving them just what they need increases their chances of reading and retaining."

"For example," she adds, "the access facilitators in the clinics do not deal with bed control, so those policies hold little interest for them. Cash collection policies for the emergency department (ED) differ from the procedures used in the clinics, so it doesn't make much sense to give ED personnel the clinic policies."

"This method has proved less intimidating," Tinsley says, "and decreases the stress and pressure of learning a new job." ■

been the re-engineering of the hospital's on-line insurance verification system. As part of that process, she rewrote the 30-page insurance training manual and, with the help of an information systems (IS) person, conducted the training for all the employees who register patients, Tinsley adds.

Several training sessions were held over about a two-week period prior to the changes going live, she notes. The manual is revised periodically, Tinsley says, and she maintains those revisions.

QA process standardized

Also in her role as trainer, Tinsley developed a standardized quality assurance process for the department. "Before, each supervisor had her own way of reporting information," she explains, "and there were different standards for what was acceptable and what was not acceptable. One supervisor might have felt 95% or more was a great accuracy rate, whereas the director's vision was 97% or better."

What Tinsley devised, she adds, is "basically a manual process in which each supervisor pulls his or her access facilitators' [registrars] paperwork at the same time every quarter. They check 12 key data elements in the registrations to make sure they're all filled in the same way."

The work is scored, reviewed, and entered into a spreadsheet, Tinsley says. "We do the same thing for the electronic verification system. We get on-line reports of [employees'] percentages. They tell us how many insurance verification requests they sent out in a quarter and, out of those, how many were not verified and how many were duplicates."

When registrars send out a request, she notes, they don't get a response right away, perhaps because the system is temporarily down. "They may not know how to read [the message] and think they need to initiate another request, which is a duplicate."

The point, Tinsley says, is to reduce the duplicates since every time a request is initiated, there is a charge to the hospital.

When a registrar's scores are out of line in some way, she adds, "is when I'm summoned to work with a person."

Another facet of the training program, Tinsley points out, is a buddy system, whereby more experienced access facilitators in different areas provide training to new hires. "Training is also based on the progression of the new employee, which is good and, I think, unique with our program," she notes. "Of course, we have an expectation of when new employees should be able to "fly on their own. Intervention by me takes place if an employee exhibits needs beyond that point, usually four to six weeks out."

About the same time she was revamping the insurance verification system, Tinsley says, she also was working with the IS and managed care departments to improve the insurance plan code process.

With a large number of insurance entities listed in the master file, it was hard to define which patients qualified for certain discounts, she notes. "I worked with managed care to streamline the

(Continued on page 9)

CHS Plan Code Guide

INSURANCE COMPANY NAME	PLAN CODE	HELPFUL HINTS
Aetna	H01	Use for all Aetna plans that do not fall in any other plan category like PHCS or Health Choice. You will need to enter the correct claim address given on the card.
Alabama Behavioral Benefits Management	H51	
Alabama Youth Services	G02	
All Kids-Blue Cross	B24	
American Medical Security	H36	
BC Managed Care/DIAB	B26	Use for diabetes education. (Clinic 7 mostly)
Blue Bell Ice Cream	H52	
Blue Cross- Other	B03	Use for those local Blue Cross plans that you know do not verify through HDX.
Blue Cross- Out of State	B06	Use for ALL out of state BC plans regardless as to whether or not claims are filed with local BC. If claims do not go to local address enter the address listed on the card for claims submission.
Blue Cross- PMD	B01	Use this for The Caring Program and Federal Government also.
Blue Cross-Generic	B99	Use when the patient has BC primary and secondary. B99 is for the secondary coverage plan
Blue Cross-PMD-PEEHIP	B19	Use for all BC plans with a group number 14000
Blue Cross-PMD-SEIB	B25	Use for State Employees for Behavioral Health admissions
Central Reserve Life	H03	
Children's Rehab Services	G03	Formerly known as State Crippled Children
Cigna	H05	Use for all Cigna plans that do not fall in any other plan category like PHCS or Health Choice. You will need to enter the correct claim address given on the card.
Commercial	H23	Use only if the plan that is not listed in Insurance Master Profile. You will need to search for the insurance company to make sure that it is not set up before using this plan code.
Commercial- Generic	H99	Use when patient has two commerical plans. This plan code is for the secondary.
Coresource	H37	
Dept of Industrial Relations	G12	Federal Workers' Compensation plan
DHR	G08	Use when patient is in DHR custody and Medicaid is not active
Employee Incident	E01	Use when a CHS employee is treated as a result of a Work-Related Injury
Federated Mutual Ins	P12	
First Health	P20	Use for patients who present with cards that say First Health, CCN and/or MedNet
GCRC	R01	
General American	H39	
Grant Studies	R98	
Great West Life	H11	
Guardian	H12	Use for plan that say The Guardian or Guradian Life
Health Choice	P02	Use whenever you see the HC name or symbols and its other products like Beech Street and NAMCI
Health Payors Org	P56	
Health Spring	O02	
Health Spring- CHS South Only	O59	Use for patients with Health Spring that are seen as Children's South
Health Strategies	P55	
Humana	H42	

Jeff County- Cat F	J54	
Jeff County-Cat A	J50	
Jeff County-Cat B	J51	
Jeff County-Cat C	J52	
Jeff County-Cat D	J53	
Jeff County-Cat E	J58	
Jeff County-Cat G	J55	
Jeff County-Cat H	J56	
Jeff County-Cat I	J57	
Jefferson County	J01	
Mailhandlers/C N A	H06	
Managed Health Funding	P19	
MCE Benefits Mgnt	H56	
Medicaid	D01	
Medicaid-Dental	D06	
Medicaid-Dialysis	D04	Use for Dialysis patients only
Medicaid-Out of State	D05	Use for all Medicaid plans that are not for Alabama
Medicare	M01	
Medicare-Part B Only	M03	Use only if the patient does not have Part A benefits. Part B covers outpatient visits only.
Mental Health Network	H54	
Mutual of Omaha	H20	
NOVA Net	P57	
Part H Funding	G10	
Patient First	D13	
Patient First-Dental	D19	
PHCS	P58	Use for all plans that have PHCS or Private Healthcare Systems on the card, even if the card has another type of participating plan name.
Principal	H28	Use for plans that say The Principal or Principal Financial
ProAmerica	O09	
Prudential	H31	
Retail Wholesale	H34	Use for all Outpatient visits for RWDSU. Inpatient stays are Blue Cross-PMD.
SCT Blue Cross	K02	Stem Cell patients
SCT International Pt	K06	Stem Cell patients
SCT Medicaid	K01	Stem Cell patients
SCT Other	K99	Stem Cell patients
SCT Self Pay	K07	Stem Cell patients
SCT The Oath	K04	Stem Cell patients
SCT United Healthcare	K03	Stem Cell patients
SCT United Res Network	K08	Stem Cell patients
SCT VIVA	K05	Stem Cell patients
Self Pay	S01	
Shaw Industries	H46	
Stem Cell Donor	K98	Stem Cell patients
Tricare/Champus	C01	**Use for Champus, ChampVA, and Tricare plans**
Tricare/Champus-Dntl	C02	Use for Champus and Tricare Dental visits
Tyson Foods	H47	
UAB Atheletics	T01	
United Benefit Life	P52	
United Foods	H48	May also read UFCW
United Healthcare HMO	O01	Use for UHC plans identified as HMO, Select, Select Plus, Choice and Choice Plus
United Healthcare Other	P60	Use for UHC plans identified as Options and Managed Indemnity
United Medical Resources	P53	
VIVA	I02	
Wausau Life Insurance	P14	

Source: Children's Health System, Birmingham, AL.

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process and to decrease the number of errors [associated] with certain plan codes."

In addition, Tinsley says, they minimized the number of plan codes by purging those that were no longer in use, but whose presence in the list increased the likelihood of error.

Tinsley provided registrars with an insurance plan code guide sheet that includes the insurance company name, the plan code, and hints to help in selecting the correct one, she adds. **(See plan code sheet, pp. 7-8.)** "Some of the insurance companies may lease the network to other managed care organizations, so we only have one code in our system." With the help of the plan code guide, Tinsley says, registrars know to use that code for the other plan names.

"It was a huge effort," she says. "I even collected insurance cards so [employees] could see the different types — what cards looked alike and could be confused."

Personalizing training

There are a couple of things, Tinsley says, that help her manage her training responsibilities while also meeting the demands of being a supervisor.

"The redirected focus on how to train our staff has made the difference," she notes, as has personalizing the training to address the specific needs of one person.

And, she adds, "While I am always thinking of ways to improve the jobs our access facilitators do, I am not on a training call every day."

To access departments without designated training personnel, Tinsley strongly recommends having "one person or a few people who really know and understand the processes and who can convey [that knowledge] to staff members."

"Accountability is hard to place," she says, "if training is no one's or too many people's responsibility."

One of the most gratifying parts of the personal approach to training, Tinsley says, is that "it makes the employees feel they really have somebody to go to. I had one [registrar] say I made a difference in her deciding to stay."

"I sat by her side for a week to make sure she didn't feel out of the loop and really understood what she was supposed to do."

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System takes initiative with ED overcrowding

Focus is on keeping patients informed

Educating the public, keeping customers informed, and enlisting volunteers to serve as patient liaisons and advocates are the three main components of an ambitious campaign by Baptist Memorial Health Care in Memphis that aims to reduce emergency department (ED) overcrowding.

"Basically, ED overcrowding is a national crisis, and we're trying to do something about it," says **Chuck McGlasson**, RN, MSA, director of emergency services and pediatrics for Baptist Memorial Hospital-Memphis. A Tennessee Hospital Association study released in December 2002 found that ED visits in the state had increased 31% over three years, or twice the national rate.

Although Baptist Memorial officially launched its campaign in November, preparations had been under way for the past two years, McGlasson notes. During that time, he says, the health system pulled itself from the depths of ED patient satisfaction scores — "something around the 15th percentile" — to a recent rating above the 85th percentile.

"Keeping the patient and the family informed is one of the main satisfiers," he says. That means answering the questions, "When will the doctor see me, when will the X-rays be back?" and, most important, "When am I going to be out of the waiting room and back in the treatment area?"

Patient communication, McGlasson adds, "means ensuring that patients in the ED understand what is going on with their visit from the time they present until the time they're discharged."

To address that core issue, he says, Baptist Memorial has made significant changes in its ED operation, including implementing fast-track registration and adding personnel during its busiest hours.

"Instead of patients just seeing a triage nurse when they present, we now have two registered nurses and a paramedic during our peak times of 5 p.m. to 1 a.m.," he says. "We've added these extra people to check on patients and keep them informed.

"The paramedic, for example, is out in the waiting room, following up with patients and checking to see if their condition changes," McGlasson notes. "[The paramedic] can draw blood, do EKGs, and go out there and keep the patient informed."

Part of the communication effort, he explains, focuses on letting patients know how the ED works. "A lot of people think it's first come, first served. They don't realize it's about [who needs] urgent and emergent care."

Instituting the fast track program in February 2002 helped boost patient satisfaction scores by reducing wait times, McGlasson says. "We feel like running a successful ED means having a successful fast track."

With 20%-25% of patients — those who might normally be treated in what Baptist Memorial calls "minor med" facilities — directed to the completely separate fast-track area, he adds, ED patients "are able to get seen pretty quickly."

The hospital's ED registration process, McGlasson notes, is done entirely at bedside. "When patients come in, they talk to an emergency medical technician or a unit coordinator at the front desk, give their name and chief complaint, and immediately go to triage." Once the patient is in a room, he adds, "registrars go in and catch up at that point. We don't do front-end registration."

To help explain such things as ED processes and how staffing works, among other topics, Baptist Memorial has created a magazine to be distributed in the waiting area, McGlasson says.

The public education piece of the campaign, he explains, has to do with addressing national ED issues, such as defining urgent vs. emergent care and emphasizing other care options, such as the physician's office or a minor med clinic.

General tips are offered, including the suggestion to get a flu shot, he adds. "Having the flu really contributes to the winter [ED crowding] crisis."

To get these messages across, McGlasson says, "We've got billboards up in our area, ads in the newspaper, and some television commercials in the works."

Response has been positive, he notes. "Several people wrote letters to the newspaper saying how glad they were that we were doing this campaign." Comments centered on the importance of addressing the issue of ED use by those who are not seriously ill, he adds.

Volunteering in the ED

Perhaps the most innovative facet of Baptist Memorial's campaign is the creation of a volunteer ED corps, called "Experience Critical," for the health system's three metro EDs.

In a divergence from the more typical senior citizen volunteer, McGlasson explains, the health system will launch a recruitment campaign targeting college-age students looking to enter the health care profession. The idea, he adds, is to find young people who "want to get in, see what's going on, and be able to interact with patients, family members, and friends."

Training will be provided, he says. "We're in the process of defining their duties. They won't be hands-on, but will be keeping people updated, running errands, keeping families informed — all kinds of things."

Fueling Baptist Memorial's efforts, McGlasson notes, has been its affiliation since October 2002 with "IMPACT," the "action network" of a national not-for-profit organization called the Institute for Healthcare Improvement (www.ihi.org).

"It's a nationwide initiative," he says. "You get to network with hospitals all over the country. We have a listserv where people who are doing the same things you're doing can answer your questions. It's a pretty good community of experts."

One of the IHI focuses, McGlasson adds, "is to look at flow across the continuum, from the time the patient comes in to the time they leave, whether they are discharged [from the ED] or they go to the floor."

[Editor's note: More information on Baptist Memorial's ED campaign is available at the health system's web site, www.bmhcc.org.] ■

AMs still unclear about stabilization vs. triage

Despite new EMTALA rule, debate continues

Access managers continue to debate the intricacies of the Emergency Medical Treatment and Labor Act (EMTALA), despite the publication of an EMTALA final rule on Sept. 9, 2003, by the Centers for Medicare & Medicaid Services (CMS). The rule became effective Nov. 10.

The challenge, access professionals indicate, is in how to translate the EMTALA regulations into hospital policy, particularly as regards when financial information can be discussed with a patient.

"The big question is the stabilization vs. triage issue," says **Monika Lenz**, CAA, admitting/communications team leader at Ridgecrest (CA) Regional Hospital. "Now, after triage by a nurse, you can register the patient. We're wondering about having to delay registration until after stabilization of the

patient, whatever that means."

At present, Lenz notes, access employees at her facility register ED patients after triage, at which time insurance information is verified. Now they are looking at delaying that step, with one idea being to do a quick registration that gathers only the most basic patient information.

The problem there, she says, is that entry into the computer system of just the patient's name and date of birth triggers a screen containing information — including insurance data — from previous hospital visits.

In 1986, Congress enacted EMTALA to ensure public access to emergency services regardless of ability to pay, and it seems that hospitals have struggled with its interpretation ever since.

In conjunction with the effective date of the EMTALA final rule, the director of the CMS Survey and Certification Group issued a Nov. 7 memorandum to state survey agency directors "to clarify hospitals' responsibilities when treating individuals with emergency medical conditions and to address concerns about EMTALA raised by the Secretary's Advisory Committee on Regulatory Reform."

The interim guidance, the memo explains, is to aid regional office and state survey agency personnel in enforcing the regulation until the release of Revised Interpretative Guidelines for EMTALA, which are being developed. It also may provide some help to access managers.

The memo, available at www.cms.hhs.gov/medicaid/survey-cert/letters.asp, says, among other things, that CMS "would like to take this opportunity to clarify its policy regarding when a patient is *stabilized* and the hospital's EMTALA obligation to *inpatients."*

In a summary of the final rule provisions relating to EMTALA, the memo points out that "the rule codifies existing policy prohibiting a hospital from seeking authorization from an individual's insurance company until a medical screening exam has been provided and any necessary stabilizing treatment has been initiated."

Although this policy is in the *CMS State Operations Manual*, and was the subject of a Joint Advisory Bulletin between CMS and the Office of the Inspector General in 1999, it never had been codified in the Code of Federal Regulations, the memo states.

Also clarified in the final rule, the memo goes on to say in a later paragraph, is that "when an individual comes to the dedicated ED for nonemergency services, and from the nature of his or her request it is clear that the individual is not making a request, or having a request made on his or her behalf, for examination or treatment for an emergency medical condition, the hospital is not obligated to conduct a comprehensive medical screening exam."

"Implicit in the guidance," the memo further notes, "is the notion that it is permissible for a registered nurse to conduct the medical screening exam, as long as the nurse is considered to be qualified medical personnel [QMP] by the hospital and is acting within the scope of his/her license."

In a provision intended to address hospitals' uncertainty regarding stabilization, the memo states, the regulation defines "stabilized" as the point when "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."

The *State Operations Manual* further clarifies the regulation, the memo points out, by providing that the "treating physician or QMP attending to the person in the emergency department/hospital has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved."

The memo goes on to explain that to be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may persist. It gives the example of a patient who is treated for the acute respiratory symptoms of an asthma attack and so is stabilized, even though the underlying condition of asthma still exists.

[Editor's note: Access professionals who would like to offer comments on how their hospitals are interpreting and implementing the revised EMTALA rule are asked to contact editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.] ■

COMING IN FUTURE MONTHS

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NEWS BRIEFS

'Think beyond the patient' when SARS is suspected

Hospital workers should "think beyond the patient" and consider whether anyone accompanying a severe acute respiratory syndrome (SARS) patient to the emergency department (ED) also could infect people at the hospital, an expert from the Centers for Disease Control and Prevention (CDC) has advised.

As health care officials prepared for a possible re-emergence of SARS, a CDC epidemiologist reviewing lessons learned from the 2003 SARS outbreak gave that advice in a recent audio conference.

The epidemiologist cited a case in Toronto in which a patient brought into the ED with symptoms of SARS was accompanied by his wife, who ended up infecting others in the waiting room because she was not given a mask or put under surveillance. In addition, the epidemiologist said, nurses and other hospital employees should be versed in how to correctly use masks and other forms of personal protective equipment.

Several hospitals listening in on the audio conference, sponsored by the Health Research and Educational Trust, said they had established hotlines for potential SARS patients and were implementing respiratory etiquette strategies to prepare for a potential recurrence. Additional SARS preparedness recommendations can be found in a CDC draft guidance document at www.cdc.gov. ▼

JCAHO quality reports available on Internet

Performance information for Joint Commission on the Accreditation of Healthcare Organizations-accredited health care organizations is expected to be publicly available on the Internet, beginning July 2004, its board of commissioners confirmed at a recent meeting.

These quality reports will include information on an organization's accreditation status, accredited services, and compliance with the Joint Commission's Patient Safety Goals and Quality Improvement Goals.

The organization also clarified its second National Patient Safety Goal, which requires hospitals to use standard abbreviations, acronyms, and symbols to improve the effectiveness of communication among caregivers. ▼

Grievance vs. complaint clarified in SHCA guide

Access managers and other hospital personnel can get help in separating patient grievances from complaints in a guide offered by the Society for Healthcare Consumer Advocacy (SHCA).

A document identifying the differences between a complaint and a grievance is available on-line at the SHCA web site, www.shca-aha.org. The guide was created to help members of the American Hospital Association affiliate group distinguish between a complaint and a grievance, based on the Centers for Medicare & Medicaid Services patient grievance regulations.

Examples of the differences include: "An issue is not a grievance if it can be handled on the spot by staff present," and "Billing issues are not considered grievances unless the patient is disputing charges due to poor care or service." ■