AMERICAN HEALTH CONSULTANTS®

ED Management®

The monthly update on Emergency Department Management

Vol. 12, No. 1

Inside

■ **Dual staffing and EMTALA:** Know the risks of this new trend 3

■ **Managed care contracts:** Many violate EMTALA regs, so check yours 5

■ **Hot issues for 2000:** What to expect from ACEP 6

■ **Patient rights laws:** Find out the latest news 7

■ **Do you know what to expect after a terrorist attack?** Patients come in two groups. 8

■ **HCFA's switch to APCs:** Here's what you need to do now 9

■ **New Joint Commission standards:** Get ready to revamp your pain management 10

January 2000

It's finally here: Special bulletin clarifies EMTALA regulations

Use this tool to educate staff, administrators, managed care, physicians

Are you still having problems with managed care contracts conflicting with Emergency Medical Treatment and Labor Act (EMTALA) requirements? Finally, a special advisory bulletin has been published to clear up any misconceptions.

The bulletin was jointly issued by the Office of the Inspector General (OIG) in Washington, DC, and the Health Care Financing Administration (HCFA) in Baltimore in the Nov. 10, 1999, *Federal Register*. **(See box for ordering information, p. 2.)** It warned that you must not delay screening exam or stabilization, despite any prior authorization requirements by managed care organizations (MCOs).

Still, the burden of EMTALA compliance falls entirely on the hospital, not the MCO, stresses **Charlotte Yeh**, MD, FACEP, medical director of Medicare Policy at the National Heritage Insurance Co. in Hingham, MA. "Even though the OIG and HCFA would like to extend some of these requirements to the managed care side, they don't have the statutory authority to do that," she says.

Executive Summary

The Office of the Inspector General and the Health Care Financing Administration have published a special advisory bulletin warning that you must not delay medical screening exams or stabilization, even when managed care plans require prior authorization.

- Medicare and Medicaid managed care organizations were put on notice that the practice of requesting prior authorization is illegal under the Emergency Medical Treatment and Labor Act (EMTALA) and the Balanced Budget Act.
- You can ask about payment after stabilization has commenced.
- Only staff knowledgeable about EMTALA should answer financial questions from patients.
- Consistently long waits could be interpreted as a pattern of encouraging patients to leave without treatment.

Advisory bulletin available

The special advisory bulletin was published by the Washington, DC-based Office of the Inspector General (OIG) and the Baltimore-based Health Care Financing Administration (HCFA) in the Nov. 10, 1999, *Federal Register*. The *Federal Register* is available at most public libraries.

To order copies of the Nov. 10 edition, send your request to: New Orders, Superintendent of Documents, P.O. Box 371954, Pittsburgh, PA 15250-7954. Specify the date of the issue and enclose a check or money order payable to the superintendent of documents, or enclose your Visa or Mastercard number and expiration date. Credit card orders also may be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost for each copy is $8.

This document also is available from the *Federal Register* on-line database through GOP Access, a service of the U.S. Government Printing Office. The superintendent of documents home page address is www.access.gpo.gov/su_docs/. The bulletin also is available on the Office of the Inspector General's Web site, www.hhs.gov/oig. Click on "What's New" to access the bulletin. ■

(See story on managed care contracts, p. 5.)

The bulletin serves as a strong incentive for you to provide additional education about EMTALA, says **Larry Bedard**, MD, FACEP, former president of the American College of Emergency Physicians in Dallas and president of Bedard & Associates, a Sausalito, CA-based consulting firm specializing in ED management and EMTALA. "There is still a fundamental lack of knowledge about patients' rights and our roles and responsibilities with EMTALA," he says. "ED managers across the nation should take a copy of this bulletin, give it to their medical staff and administrators, and conduct an educational program on EMTALA."

The bulletin serves two purposes, says **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, an emergency medicine coding and consulting firm in Jacksonville, FL. "It assists hospitals in developing policies and procedures for staff that clearly delineate their responsibilities under EMTALA. It also puts Medicare and Medicaid managed care organizations on notice that their common practice of requesting prior authorization is illegal. At long last, the OIG and HCFA have provided the necessary clarifications in this area."

Here are key points in the bulletin:

• **Obtaining payment authorization before the medical screening exam and onset of stabilization is a violation.**

This is the most important clarification in the bulletin, says Bedard. "It's now very clear that hospitals cannot make arrangements with MCOs to do prior authorizations, which has been going on for some time."

• **You cannot obtain financial responsibility forms before the patient is stabilized.**

If interpreted strictly, this will force hospitals to re-examine the entire ED registration process, says Yeh. "That's because in many EDs, routine registration involves finding out financial responsibility at the same time the patient is signing consent for treatment," she says. "But it's pretty clear from this report that is not considered permissible behavior."

• **You don't have to wait until the end of stabilization to ask for payment authorization.**

"You can ask for authorization of payment once stabilization has commenced, so that is a major point of confusion that is now clear," says Yeh.

• **You may ask about insurance, but only if it doesn't delay care.**

Asking if a patient has insurance is considered to be part of the reasonable registration procedure, Yeh explains. "Now it is more clear that you may ask whether or not an individual is insured, as long as your query does not delay screening and treatment."

However, if any hospital staff member initiates a discussion with a patient about an MCO's prior authorization requirements, and it delays the medical screening exam, it is a clear violation of EMTALA, she warns. "So this is a strong incentive for hospitals to have educational programs for their staff about EMTALA."

• **There are specific requirements for Medicaid and Medicare MCOs.**

COMING IN FUTURE MONTHS

- ■ Update on ambulance diversion
- ■ Prepare for flu pandemic
- ■ Tips for nurse recruitment
- ■ Unique patient triage form

The bulletin stressed that although EMTALA doesn't apply to MCOs, there are other regulations that ban prior authorization, such as the Balanced Budget Act (BBA). "Under the BBA, the MCOs must pay based on the prudent layperson standard," Yeh notes. "So you can use that information as support, if you experience any difficulties with managed care plans." **(See story on managed care and dual staffing, below right.)**

• Only staff who are knowledgeable about EMTALA should answer financial questions from patients.

Any question about payment for ED services must be answered by someone who understands EMTALA requirements, says Yeh. "You need to make sure that the patient is aware that irrespective of their ability to pay, the hospital stands ready and willing to provide medical screening and stabilization treatment if needed." For example, a patient might say, "I want to get an X-ray because my back bothers me, but my primary care physician refuses to do this. How much does it cost?"

Now you can have that discussion, but only if you first explain that patients have a right to a medical screening exam and stabilization treatment regardless of their ability to pay, Bedard says.

Your ED will have to demonstrate to HCFA surveyors that there is a staff person knowledgeable about EMTALA on duty at all times, Yeh advises.

• You must document voluntary withdrawal.

If patients refuse treatment, you need to document three things, according to Yeh:

— The patient was offered an exam and treatment.

— The patient was informed of specific benefits and specific risks.

— All reasonable steps to obtain a written informed consent were taken.

If a patient leaves and doesn't tell anyone, document that the patient arrived and the time it was discovered that the patient left without being seen. "Not everybody takes as much care as they should to record when they've identified that a patient has left," she says. "Make sure you retain all those records."

• Long waits could be considered an EMTALA violation.

The bulletin warns providers not to develop a pattern of encouraging patients to leave without treatment, which could be an attempt to remedy long waits. "We are waiting to see how HCFA is going to be enforcing this, since they are saying that waiting times could be an indicator of encouraging patients to leave without being seen," Yeh says. "It's basically a warning to EDs to take a good look at their waiting times."

• You can contact a patient's physician at any time to seek advice about medical care.

Although you can't request authorization for payment until after the medical screening exam is completed, there's no problem with contacting a patient's physician at any time to get information about the patient's medical history. As long as you don't withhold or delay any portion of the medical screening exam, you shouldn't hesitate to contact a patient's physician. "They didn't want people to be afraid to call," Yeh explains.

ED staff were concerned that if they called the physician, and during the course of the conversation the topic of reimbursement came up, it could be interpreted that the purpose of the call was for payment authorization, Yeh says. "But if you document clearly that you called the primary care physician for medical information that will help you to care for the patient, it is not an EMTALA violation." ■

Sources

- **Larry Bedard**, MD, FACEP, Bedard and Associates, 88 Prospect Ave., Sausalito, CA 94965. Telephone: (415) 332-1893. Fax: (415) 332-1894. E-mail: lbedard@aol.com.
- **Caral L. Edelberg**, CPC, CCS-P, Medical Management Resources, 9550 Regency Square Blvd., Suite 1200, Jacksonville, FL 32225. Telephone: (904) 725-4889. Fax: (904) 724-1948. E-mail: mmr@leading.net.
- **Charlotte Yeh,** MD, FACEP, National Heritage Insurance Co., Box 3033, Hingham, MA 02043. Telephone: (781) 741-3122. Fax: (781) 741-3211. E-mail: charlotte.yeh@eds.com.

Beware: Dual staffing is legal but risky

You might not have heard of dual staffing yet, but chances are you will soon. An increasing number of managed care organizations (MCOs) such as Kaiser Permanente in Colorado, Ohio, and California, are staffing EDs with their own physicians who see only the plan's patients. Many practitioners of emergency medicine argue that the practice is a violation of the Emergency Medical Treatment and Labor Act (EMTALA), because patients are not receiving equal care based on their insurance status.

In a special advisory bulletin was issued by the Office of the Inspector General (OIG) in Washington, DC, and the Health Care Financing Administration (HCFA) in Baltimore, the question was addressed for the first time. It was ruled that dual staffing does not violate EMTALA as long as there is equal access to care for both sets of patients.

However, the bulletin made it clear that the practice still carries serious risks, warns **Charlotte Yeh**, MD, FACEP, medical director of Medicare Policy at the National Heritage Insurance Co. in Hingham, MA. "If you allow dual staffing in your ED, you run the risk of violations because it's clear that HCFA and OIG will monitor these dual staffing arrangements accordingly," she stresses.

You need to take steps to ensure there are no violations of EMTALA, she advises. "For instance, there should be a procedure that allows patients to cross over between tracks when appropriate. So if one side of the ED is very busy and the other side is slow, there should be a way you can utilize both tracks."

6 potential violations

The bulletin gave these examples of potential violations:

• The emergency department directs a hospital-owned and operated ambulance differently in field care or facility destination depending on which members of a dual staff (that is, MCO or non-MCO physicians or practitioners) are on the radio to emergency medical services (EMS) or are expected to see the patient.

• The emergency department alert status affecting acceptance of EMS cases differs depending on which "side" (MCO or non-MCO) is expected to see the patient.

• The MCO or non-MCO track is understaffed or simply overcrowded, and a patient in a particular track is subjected to a delay in screening and stabilizing treatment, even though a physician in the alternative track was available to see the individual.

• There is no emergency department policy or procedure, custom, or practice that requires crossover coverage between the dual staffs as required for patient care. (Delays in screening or stabilization of patients on one track but not the other are delays in screening or stabilization based on the insurance status of the individual. Thus, they represent potential violations of EMTALA.)

• The hospital's emergency department quality oversight plan differs between the two "sides" (MCO and non-MCO) of the dually staffed ED.

• Protocols for transfer of unstable patients differ other than administratively. For example, the substance of stability determination criteria between the two staffs may differ, or patients who are unstable may be transferred routinely to different facilities that are not equivalent to each other in level of care or distance, and their destinations depend on their insurance status.

The bulletin stressed the risks of dual staffing, but some EMTALA experts were hoping that HCFA and the OIG would rule it was a clear-cut violation. "Dual staffing with physicians seeing only managed care patients is discriminatory," argues **Larry Bedard**, MD, FACEP, former president of the American College of Emergency Physicians (ACEP) in Dallas and president of Bedard & Associates, a Sausalito, CA-based consulting firm specializing in ED management and EMTALA. "If a white, insured, middle-class patient gets seen immediately, and an indigent patient waits for two hours, that is an EMTALA violation," he says. "To comply with EMTALA, the doctors need to see the next available patients, not cherry-pick their own HMO patients."

The purpose of EMTALA is to ensure patients get the same standard of ED care, regardless of their insurance status or ability to pay, says Bedard. "Dual staffing results in different access and different standards of care. Patients aren't getting equal care if they have different pharmacies and different access to specialists."

To educate administrators about EMTALA concerns and dual staffing, give them a copy of ACEP's position paper and letter about dual staffing sent to HCFA, Bedard suggests. (Both documents can be downloaded from the ACEP Web site at www.acep.org.)

You can use those materials to educate hospital administrators, Bedard advises "You can say, 'Here is a nationally recognized authority who thinks dual staffing should be illegal, and here are all the problems they see with this practice.'" ■

Know 6 key points of EMTALA bulletin

The special advisory bulletin on the Emergency Medical Treatment and Labor Act (EMTALA), jointly issued by the Office of the Inspector General in Washington, DC, and the Health Care Financing Administration in Baltimore, provides the following key clarifications, according to **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, a Jacksonville, FL-based emergency medicine coding and consulting firm.

1. Appropriate medical screening examinations are mandated for any person who comes to the hospital seeking emergency medical services. Those examinations must include any and all services necessary and available at the hospital, including medically appropriate ancillary services required to stabilize the medical emergency as well assurance of patient transfer to a hospital with necessary services.

Do your contracts violate EMTALA?

A special advisory bulletin was published to emphasize that no managed care contract can supersede a hospital's duties under the Emergency Medical Treatment and Labor Act (EMTALA), says **Charlotte Yeh**, MD, FACEP, medical director of Medicare Policy at the National Heritage Insurance Company in Hingham, MA. "So the message is for hospitals to be sure that their contracts are in compliance," she explains.

The bulletin, issued by the Washington, DC-based Office of the Inspector General and the Baltimore-based Health Care Financing Administration, clarifies that your obligations under EMTALA remain, regardless of any contracts with managed care organizations (MCOs). Managed care contracts that require prior authorization are in direct conflict with EMTALA requirements, and those type of contracts still are being signed, says Yeh.

In recent months, there has been a movement away from ED prior authorization, Yeh says. EMTALA is one reason for that, she says. "There is also the growing consumer backlash, patient protection legislation at the state level, and the fact that access to emergency services with the prudent layperson definition is a fairly well supported concept at the bipartisan level and certainly on a consumer level." All those factors have led to lessening of prior authorization for emergency services, Yeh explains. "But the issue has certainly not gone away, and EDs must remain vigilant."

Be careful about who is handling your contracts with MCOs, warns **Caral Edelberg**, CPC, CCS-P, president of Medical Management Resources, a Jacksonville, FL-based emergency medicine coding and consulting firm. "One of the more significant problems I run into with audits is when uninformed hospital personnel are given the responsibility to negotiate managed care contracts," she says. "Under no circumstances should these contracts be developed or signed without review and approval of ED staff and hospital attorneys."

Many managed care contracts reviewed directly violate federal law, Edelberg reports. "In addition, coders and business office personnel should be educated about EMTALA provisions and trained to spot problems as they manage claims each day," she says.

Hospitals and ED should provide informational brochures or informational packets for patients and insurers to educate them, she recommends. "The hospital will need to take the lead in notifying the public and the insurers of their rights and obligations." For example, hanging signs in the ED that state patients have a right to a medical screening exam and stabilization treatment regardless of their ability to pay would be helpful, she suggests. ■

2. Hospitals may not delay a medical screening exam or stabilizing medical treatment to inquire about "method of payment or insurance status."

3. Sanctions and exclusion from the Medicare program are applicable to both hospital and physicians.

4. Enrollees of managed care plans are provided protection from preauthorization prior to a medical screening examination as EMTALA prohibits requiring members to seek prior authorization for emergency medical services, defined under the prudent layperson provisions. Further, the bulletin clarifies that "no contract between a hospital and managed care plan can excuse the hospital from its anti-dumping statute obligations." The hospital must provide the services required under the anti-dumping provisions.

5. Issues relating to dual staffing of emergency departments by hospital ED physicians and managed care organization (MCO) physicians to facilitate emergency department management of MCO enrollees have emerged as problematic when non-managed care enrollees incur discrimination in receiving prompt and appropriate medical screening examinations.

The bulletin clarifies that the dual-staffing arrangements must ensure that patients receive equal treatment by ED and MCO physicians, and neither may delay provision of medical screening to inquire about method of payment. Dual-track emergency departments must be adequately staffed and provide good access to all medical capabilities of the hospital to ensure all patients are treated equally.

6. Hospitals should be aware that Medicare and Medicaid managed plans are restricted from requiring prior authorization for emergency services and must pay for emergency services whether or not the hospital participates with the plan. The prudent layperson standards apply. ■

ACEP's 2000 goal: Access for the uninsured

Prudent layperson standard also pushed

The most important issue facing emergency medicine this year is access to emergency services for both the insured and uninsured, emphasizes **Michael T. Rapp**, MD, FACEP, current president of the American College for Emergency Physicians (ACEP) in Dallas and an ED physician at the department of emergency medicine at Arlington (VA) Hospital. Here are several issues that will affect you in 2000:

• **Lack of universal health coverage.**

"Many people feel that the problem of the uninsured having access to health care should be the next fundamental issue that ACEP devotes attention to, after prudent layperson legislation is resolved," reports Rapp. An ACEP council voted to hold a conference this year to evaluate that issue.

As the number of uninsured patients continues to grow, care in the ED is affected, Rapp says. "Because of our failure to have universal health care coverage, there is an impact on the insured when they seek ED care. If we had universal health coverage, EDs would operate more efficiently."

• **Passage and enforcement of legislation requiring all health plans to use the prudent layperson standard.**

ACEP will continue to pursue this issue aggressively, says Rapp. "We're at a stage right now when we have complete acceptance of this standard nationally. We've gotten it accepted in federal programs and at the state level." **(See story on federal legislation that requires health plans to use the prudent layperson definition of an emergency, p. 7.)**

Executive Summary

The growing problem of the uninsured population may be the next major issue the American College for Emergency Physicians (ACEP) will focus on in 2000, after prudent layperson legislation is passed and enforced in all states.

- Prudent layperson definition standards have been adopted in 28 states, but ACEP is now focusing on making sure those laws are adequately enforced.
- ACEP's Emergency Practice Committee is evaluating telephone advice and patient satisfaction survey tools.
- ACEP is developing an extended course to teach physicians management skills.

Prudent layperson definition standards have now been adopted in 28 states, he notes. "The next frontier is making sure those laws are adequately enforced. In some instances, the provisions are not being implemented properly." Although prudent layperson definition requires that payment be based on the patient's presenting symptom, some payers in states that have passed legislation still evaluate the claim based on the eventual diagnosis, he explains.

ACEP chapters working on prudent layperson enforcement include Maryland, Florida, New York, Michigan, and Washington, he says. If there is a problem with enforcement of prudent layperson legislation in your state, contact one of your state's ACEP chapters or the national office, he suggests. "Even though the standard is clear and state laws have been passed, some payers are either not aware of this or choose to ignore it."

• **Education about fraud and abuse laws.**

It's important that regulations be understood clearly, so physicians aren't reluctant to put in a valid claim for fear of being accused of fraudulent activity, says Rapp. "Managers need to make sure your documentation is adequate to get the reimbursement you are entitled to."

The government has allocated resources into Medicare fraud enforcement, which creates a much greater danger for physicians in general, he maintains: "The Office of Inspector General has created compliance guidelines, so it's advisable for anybody who puts in a claim for payment to be familiar with these and be aware of potential penalties." Penalties can include fines of up to $10,000 per occurrence, he stresses.

ACEP has developed an information paper on compliance issues for guidance of physicians, which is available on its Web site (www.acep.org).

• **Ambulatory patient classifications (APCs)**.

There is a concern about what effect the proposed switch to APCs for outpatient services will have on emerging trends in emergency medicine, such as observation units, Rapp explains. **(For the latest information on APCs, see story, p. 9.)**

There is a question about whether EDs will be reimbursed for observation under APCs, he notes. "This is an important area of growth in emergency medicine, and there needs to be an adequate financing mechanism to do this. Otherwise, it will be hampered."

If the ED physician is responsible for the care and evaluation of a patient over a longer period of time, hospitalization can be avoided, but there needs to be reimbursement for this service, stresses Rapp. "If there isn't, EDs will want to tend to keep a patient briefly and admit them to the hospital, which would be a bad trend in the long run."

• **Evaluation of patient satisfaction tools.**

ACEP's practice and research committee is evaluating

Source

- **Michael Rapp,** MD, FACEP, Arlington Hospital, Department of Emergency Medicine, 1701 N. George Mason Drive, Arlington, VA 22205. Telephone: (703) 558-6169. Fax: (703) 558-5355. E-mail: mrapp@acep.org.

patient satisfaction survey tools and reviewing the methodology used, he reports. The issue is that patient satisfaction tools are increasingly used by hospitals as a means to evaluate the various services provided, he explains. "As a result, ED physician groups and individual physicians are increasingly being evaluated this way. Poor survey results can result in the hospital terminating a contract or groups terminating individual physicians, even if there are no specific quality concerns otherwise raised."

It is important that those tools be accurate and statistically valid measures of customer satisfaction, he stresses; in addressing physician performance, they also need to focus on areas the physician can control.

• **Preparation of physicians for managing the ED.**

There is a trend toward physician management of the ED, says Rapp. Physicians are more commonly being given responsibility for overall management of the entire ED, including nursing and registration, he explains. "We find a lot of physicians are actually going to get a MBA, which is probably not necessary to manage an ED. But clearly something more is needed than the training given in residency programs where mainly clinical information is taught."

ACEP is developing an extended course that would teach physicians management skills, including budgeting and human resources, he says.

• **Development of a bill of rights for physician.**

ACEP is developing an ED physician's bill of rights because most physicians work under contract unless they are directly employed by the hospital. "It will basically outline what the rights of physicians should be and address contract issues such as due process," says Rapp. In many contracts, physicians can be terminated without any reason given. "It's not commonly done, but the possibility makes people feel insecure," he says. "It would be better if physicians were not subject to arbitrary termination."

A formal policy statement would allow physicians to ask employers if they adhere to the ACEP ED physician bill of rights and use the tool to evaluate potential employment opportunities, he explains.

• **Evaluation of telephone advice.**

ACEP's Emergency Practice Committee is evaluating telephone advice. "This is frequently offered by EDs as a program to help managed care companies, so we are considering the quality issues raised by such activity," he says.

• **Improvement of access to reimbursement data.**

ACEP is working to make reimbursement information more accessible on its Web site, he says. "It's the best way to get information out because it's constantly changing."

ACEP's reimbursement staff field frequent questions on proposed changes in CPT coding requirements, which could be posted on the Web site, he says.

• **Formation of a new medical/legal committee.**

ACEP has formed a new committee to help members analyze medical and legal issues that arise, such as fraud and abuse and the anti-kickback law. Information papers on key medical legal issues will be developed. ■

Update on patient access to EDs: Share good news

There is finally some good news on the patient protection legislative front: The Norwood/Dingell bill (HR 2723) was passed in the U.S. House of Representatives. This bill would establish a national standard of emergency care and protect patients from claims denials and requirements for prior authorization by managed care plans.

"The legislation passed by the House will ensure that all patients in managed care plans can access emergency care whenever and wherever they need it, without fear of being stuck with the bill," says **John Moorhead**, MD, FACEP, immediate past president

Executive Summary

The Norwood/Dingell bill, passed in the House of Representatives, would establish a national standard of emergency care and protect patients from claims denials and managed care plans' requirements for prior authorization.

- The bill will be a significant health care issue in this year's presidential election, but it's doubtful that federal legislation will be passed before then.
- It would establish a national prudent layperson standard, which requires health plans to base emergency care coverage on symptoms and not a final diagnosis.
- Patients who pay for their health insurance need the same emergency care protections as individuals enrolled in federal government, Medicare, and Medicaid health plans.

of the American College of Emergency Physicians (ACEP) in Dallas.

The House bill, which was introduced by Rep. Charlie Norwood (R-GA) and John Dingell (D-MI) would establish a national prudent layperson standard and require health plans to base emergency care coverage on a patient's symptoms and not a final diagnosis, says Moorhead.

HR 2723 also extends the prudent layperson standard to the approximately 161 million Americans with health insurance, unlike the legislation passed by the Senate [S. 1344], which only covered 48 million patients enrolled in self-insured health plans, explains Moorhead.

It is imperative that patients who pay for their health insurance be afforded the same emergency care protections as individuals enrolled in Medicare and Medicaid health plans, he stresses. "The emergency physicians of this country and our patients continue to call on Republicans and Democrats alike to take the steps necessary to pass meaningful patient protection legislation that includes the prudent layperson standard this year."

The bill will be a significant health care issue in this year's presidential election, but it's doubtful that legislation will be passed before then. "We are at point where it's been passed by House of Representatives, but our proposal wasn't accepted completely by the Senate version, so it's in committee," says **Michael Rapp**, MD, FACEP, president of ACEP. "Hopefully it will ultimately be adopted, but there is still plenty of work to be done." ■

Expect 2 waves of patients after terrorist attack

A study conducted after the bombing of the federal building in Oklahoma has revealed a misconception. Contrary to what most experts believed previously, there are actually two waves of patients after a terrorist attack, explains **David Hogan**, DO, FACEP, interim chair of the department of emergency medicine at the University of Oklahoma College of Medicine and the study's principal investigator.[1]

Here's what to expect if a terrorist attack occurs in your community:

• First wave.

After a mass casualty incident, the majority of patients arrive by means other than ambulance, says Hogan. "The patients who are able to extricate themselves from the scene and secure their own transport to EDs tend to be the less injured. As a result, the first group of patients arriving to an ED tend to be of less severity than those arriving somewhat later."

This phenomenon was supported by the study of the Oklahoma bombing. "The more seriously injured cases arrived later," he says.

However, the first wave of patients may put staff at risk for contamination, he warns. "These patients typically have not typically received scene evaluation [or decontamination], which may be very important for a hazardous materials event."

Decontamination is not usually effective or needed for biowarfare agents delivered by aerosol, Hogan says.[2-3] "However patients arriving in this first wave with hazardous materials or chemical warfare agent exposure will likely not have been decontaminated. Therefore, each hospital needs to have the ability to decontaminate these patients." **(For more information on patient decontamination, see *ED Management,* November 1999, p. 121, and September 1996, p. 105.)**

• Second wave.

When the first wave of patients arrives at the ED, they should be triaged to various locations in the hospital to make way for the second wave. "Consideration needs to be given to the potential of a second wave of more seriously injured patients that may arrive a short time later," says Hogan.

"There should be clear plans as to the distribution of minimal casualties within the hospital to designated areas. These areas may be staffed with a variable cadre of physicians," he explains.

However, the designated area should be supervised by a physician skilled in the evaluation and treatment of traumatic wounds and disaster-related disorders, he recommends.

Executive Summary

A study examining patient arrival at local EDs after the bombing of the federal building in Oklahoma has shown there are two "waves" of patients after a terrorist attack.

- Contrary to popular belief, after a mass casualty incident, most patients arrive by means other than ambulance transport.
- Because the first group of patients arriving at EDs are transporting themselves, they tend to be of less severity than the second wave of patients.
- While triaging patients from the first wave, you need to prepare for more serious injuries in the second.

Source

- **David Hogan**, DO, FACEP, Department of Emergency Medicine, University of Oklahoma Health Sciences Center, Room EB 328, P.O. Box 26307, Oklahoma City, OK 26307. Telephone: (405) 271-5135. Fax: (405) 271-7007. E-mail: David-Hogan@OUHSC.EDU.

"The 'two-wave' phenomenon will be modified by the type of disaster, location of the specific hospital in relation to the disaster, as well as other factors."

References

1. Hogan DE, Waeckerle JF, Dire DJ, et.al. Emergency department impact of the Oklahoma City terrorist bombing. *Ann Emerg Med* 1999; 34:160-167.
2. U.S. Army Medical Research Institute of Infectious Diseases. *Medical Management of Biological Casualties Handbook*, 2nd ed. Fort Detrick, Fredrick, MD: USAMRIID; 1996.
3. Franz DR, Jahrling PR, Friedlander AM, et al. Clinical recognition and management of patients exposed to biologic warfare agents. *JAMA* 1997; 278:399-411. ■

Outpatient PPS switch likely to be delayed

Although the switch to ambulatory patient classifications (APCs) for outpatient services has been delayed, you still should prepare now, warns **Jeffrey Bettinger**, MD, executive vice president for billing and reimbursement at Team Health's Financial Services Division in Plantation, FL, and member of the Reimbursement Committee for the Dallas-based American College for Emergency Physicians.

"You should be moving full steam ahead," urges Bettinger. "You may have gotten a reprieve, but it can take a year to accomplish your objectives in areas such as improved documentation."

As of press time, it was still unclear when the final rule would come, but implementation by July 1, 2000, is unlikely, he predicts. "A more realistic date is January 2001."

The Health Care Financing Administration (HCFA) published a proposed rule in the Sept. 8, 1998, *Federal Register* and solicited comments. (The complete regulations can be reviewed on the Web at www.nara.gov./fedreg. **See box, p. 2, for information on obtaining a copy of the *Federal Register*.**)

Under newly passed Congressional legislation, HCFA is required to make further technical revisions to the APC system and to delay implementation of a volume control mechanism for two years. "Also, to give relief to rural hospitals, hospitals with less than 100 beds will be subject to additional payments," Bettinger explains.

There will probably be a six-month waiting period after the final rule is published until implementation, but prepare now. "Documentation improvement can't be accomplished overnight," he stresses. "So even a six-month time period may not be enough, especially if you are investing in technology to improve documentation. If you don't get up to par now, you could end up losing a lot of money."

Here are things you should be doing now to prepare for the switch to APCs:

1. Improve documentation for ED visit.

"This has always been important for our professional component billing, all of which is dependent on the exact and complete documentation we provide," says Bettinger. "But for first time, documentation for both the physician and nursing staff will play a large role in the way the facility is reimbursed."

The proposed APC rule used a hybrid methodology that, at a minimum, reimburses hospital ED visits for their cost. "This combines the CPT criteria for documentation and incorporates about 20 different diagnostic categories," Bettinger says. "So it's a combination of documentation and diagnosis."

HCFA is now required to eliminate diagnoses codes in determination of service provided in the ED, he notes. "This may allow for use of straight CPT coding, very similar to that used for physician services."

ED managers and nurses will need to pay close attention to what is actually written in the medical record, Bettinger says. "Up until now, we've been reimbursed more according to cost of services rendered. But now your reimbursement is going to be dependent upon the documentation provided."

Executive Summary

Congress approved a Medicare bill that likely will delay implementation of the final rule from the Health Care Financing Administration on ambulatory patient classifications.

- Even a one-year time period may not be enough to improve documentation adequately, so ED managers must start preparing now.
- Consider investing in documentation improvement tools, such as template paper records, disk transcriptions, and computerized emergency medical records.

Source

- **Jeffrey Bettinger**, MD, Team Health, Financial Services Division, 100 N.W. 70th Ave., Plantation, FL 33317. Telephone: (954) 584-1000 ext. 2438. Fax: (954) 377-2670. E-mail: jeff_bettinger@teamhealth.com.

ACEP addresses documentation

The American College of Emergency Physicians is offering two educational conferences that address Medicare documentation requirements. A course titled "Reimbursement: Trends and Strategies for Emergency Medicine" will take place Jan. 31-Feb. 2, 2000, and a course titled "Getting Control: Effective Procedure Coding for Emergency Medicine" is scheduled for Feb. 2-4, 2000. Both will be held in Las Vegas. For details, contact:

- **American College of Emergency Physicians**, P.O. Box 619911, Dallas, TX 75261-9911. Telephone: (800) 798 1822, ext. 6, or (972) 550-0911. Fax: (972) 580-2816. E-mail: cstiles@acep.org. Web: www.acep.org.

2. Learn HCFA documentation guidelines for ED visits.

"Even though it's not important to your reimbursement now, you should at least get yourself thoroughly educated about the criteria which physicians have had to use for many years," he says.

Attend seminars and learn HCFA criteria for documentation, he recommends. **(See box, above, for information about ACEP courses.)**

3. Investigate tools that will allow you to improve your documentation.

Consider investing in template paper records, disk transcriptions, or computerized emergency medical records. "Handwritten records will become a thing of the past because it's just not a time-efficient way to document the elements which will be necessary for appropriate reimbursement," says Bettinger.

4. Track utilization and cost of equipment and drugs used.

For the first time, the costs of medications used in the ED will be bundled into a single payment for that visit, he explains. "So hospitals which don't have good control of their formulary and the medications that are dispensed in the ED will possibly end up being losers under the system."

Congress directed HCFA to pay additional amounts for certain high-cost items, such as some IV drugs and new technologies, he notes. Still, you need to have a good handle on utilization of medication and other supplies. "The way the APC system is set up, X-rays and lab will still be reimbursed separately under a fee schedule, so some ancillary services will be paid in addition to the ED visit," he says. "But supplies such as Ace wraps are all bundled into the ED visit, so hospitals should be tracking and controlling their utilization."

5. Keep abreast of reimbursement for observation services.

The proposed rule is assigning no separate reimbursement for observation services, Bettinger says. "These services will be bundled together into either a surgical code or another medical code. We still don't know what the final rule will say. But as it stands now, there is no payment for observation services as a separately identifiable service." ■

Joint Commission UPDATE

Get ready for new pain management standards

The Joint Commission on Accreditation of Healthcare Organizations has developed new standards for pain management. The new standards will be included in the 2000-2001 standards manuals and will first be scored for compliance in 2001. Your facility will be called upon to:

- recognize the right of patients to appropriate assessment and management of pain;
- assess the existence and, if existing, the nature and intensity of pain in all patients;
- record the results of the assessment in a way that facilitates regular reassessment and follow-up;
- determine and ensure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff;
- establish policies and procedures that support the appropriate prescription or ordering of effective pain medications;

• educate patients and their families about effective pain management;

• address patient needs for symptom management in the discharge planning process.

The new standards explicitly acknowledge that pain is a coexisting condition with a number of diseases and injuries and requires explicit attention. For example, a patient with breast cancer should effectively be treated not only for the actual illness, but also for any associated pain.

Last year, copies of the proposed standards were sent to accredited health care organizations and achieved an approval rating of 92%. Currently, the Joint Commission is working with other organizations to promote effective pain assessment and management. That will include production of an educational video, presentations at national and regional conferences, and educational seminars for accredited organizations. At mid-year 2000, the Joint Commission will assess the ability of accredited organizations to comply with the standards and put into place a plan for full or phased-in implementation.

Consistent assessment is sought

The new standards will ensure that pain in the ED is more consistently assessed and managed, stresses **Emory Petrack**, MD, MPH, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland. "For example, a patient presenting with a laceration or fingertip avulsion will need to have the specifics of pain management addressed, in addition to repair of the injury itself," he explains.

You will need to have a method for documenting and quantifying pain assessment, subsequent management, and the patient's response, Petrack advises. "To succeed with this goal, an ED policy regarding pain management is essential, and staff will need to be appropriately trained." ■

Sources

- **The Joint Commission on Accreditation of Healthcare Organizations**, Department of Standards, One Renaissance Blvd., Oakbrook Terrace, IL 60181. Telephone: (630) 792-5900. Fax: (630) 792-5942. E-mail: standards@jcaho.org. Web: www.jcaho.org.
- **Emory Petrack**, MD, MPH, Division of Pediatric Emergency Medicine, Rainbow Babies and Children's Hospital, 11100 Euclid Ave., Mail Stop MATH6097, Cleveland, OH 44106-6019. Telephone: (216) 844-8716. E-mail: emp4@po.cwru.edu.

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Management® is approved for approximately 18 nursing contact hours. This offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours. American Health Consultants® is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association. This activity was planned and produced in accordance with ACCME Essentials. **ED Management**® is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit. Physician members of American Health Consultants® 1999 Continuing Medical Education Council: Stephen A. Brunton, MD; Dan L. Longo, MD; Ken Noller, MD; Gregory Wise, MD and Fred Kauffman, MD, FACEP.

Subscriber Information
Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcpub.com). **Hours of operation:** 8:30 a.m.-6 p.m. M-Th; 8:30 a.m.-4:30 p.m. F, EST. Subscription rates: U.S.A., one year (12 issues), $399. With 18 Category 1 CME hours, $449. For 21 ANA hours, $449. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 or more additional copies, $239 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are $67 each. (GST registration number R128870672.)

Editor: Staci Bonner.
Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: Park Morgan, (404) 262-5460, (park.morgan@medec.com).
Managing Editor: Joy Daughtery Dickinson, (912) 377-8044, (joy.dickinson@medec.com).
Production Editor: Terri McIntosh.

Editorial Questions

For questions or comments, call Joy Daughtery Dickinson, (912) 377-8044

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 *Expect two waves of patients after terrorist attack,* p. 8.)
2. Explain developments in the regulatory arena and how they apply to the ED setting. (See *It's finally here: Special bulletin clarifies EMTALA regs,* p. 1; *Beware: Dual staffing is legal but risky,* p. 3; and *Update on patient access to EDs: Share good news,* p. 7.*)*
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by your peers in the publication. ■

(Continued from page 11)

Subscribers will be eligible to receive approximately 12 contact hours of nursing continuing education credits at no extra charge. As a subscriber to *ED Management*, you will be able to purchase an annual subscription at $149 — $50 off the regular subscription price of $199.

To reserve your subscription, please contact American Health Consultants' customer service department at (800) 688-2421 or by e-mail at customerservice@ahcpub.com. Provide the reference code "HNA 61760" to take advantage of this special offer. ■