Important Message from Medicare: One hospital’s best practices

Hospitals face a new set of challenges incorporating the Important Message from Medicare (IM) into an already full routine.

In the HCPro audioconference “The Important Message from Medicare Regulation: Typify your process and ensure compliance,” Christine Stottlemyer, CPAM, patient accounting director at Memorial Hospital in York, PA, and Marilyn Hake, RN, CCM, manager of care management (CM) at Memorial, discussed how they managed to implement and demonstrate compliance with the new process without disrupting their successful routine.

Memorial Hospital is a 100-bed acute care facility. The patient population consists of 49% Medicare and 13% Medicare Advantage. In 2007, there were 6,869 patient discharges, with the average length of stay about 3.48 days.

The patient access approach

Stottlemyer has worked in hospital receivable management for more than 25 years. In implementing the new practice, she said, her department wanted to build on the current, successful system rather than starting from scratch. She formed a task force composed of members from patient access, CM, patient financial services, and quality review and began reviewing the current process to determine how to best incorporate the new procedure into the hospital’s admission process. The following are the ways the patient access department addressed some aspects of the IM process:

➤ Obtaining signatures. When a patient is unable to sign, or a designee is not present during the admission process, the message is placed on the patient’s chart, and nursing then assumes responsibility. This system has worked well for Memorial. However, registration will send the admitting clerk to the floor to make sure the signature is obtained within two calendar days. Charts are reviewed within 24 hours and checked for that initial signature as part of the normal review process.

Stottlemyer said that it is always a team effort.

“This is really everyone’s responsibility. It’s not just access, it’s not just care management—it’s nursing, it’s physicians, it’s everyone.”

Christine Stottlemyer, CPAM

> continued on p. 2
Important Message

with the patients using the prepared script. They will obtain signatures, give the patients their copies, and deliver the original and copy to the nursing department for placement on the patients’ charts.

“The three-part form works pretty well for us,” said Stottlemyer.

➤ Education. Education about the process in the registration area is a challenge. Stottlemyer said that it is an ongoing process.

Certain education meetings during which they go over the form and hand out scripting for the staff members to use are mandatory.

“I am a firm believer in scripting,” Stottlemyer said. “We use scripting extensively. It really takes the pressure off the staff and makes their jobs a little bit easier. It also delivers a consistent message to our patients.” CM, nursing, and verification specialists also use the script.

The scripting language is taken right off the IM and is put into a concise format that highlights the most important aspects of the message and makes it easier to explain to the patient.

The hospital also has one-on-one testing by the supervisors. The access supervisor will periodically quiz staff members about certain aspects of the message: What if a patient wants to appeal? Who does he or she contact? Staff members need to be able to answer these questions for patients.

➤ The “just one more thing” attitude. Patient access gets overloaded with tasks. Stottlemyer stressed the importance of reminding registration staff members how important they are to the success of the operation.

The care management approach

Just as it was necessary for the registration department to review its processes, the CM department also had to take a look at the additional responsibilities, compliance, and time factors of the IM delivery and determine the least demanding process for its staff members.

Hake said it was important for them to be on the same page as patient access regarding the timely delivery and explanation of the message, so her department also relies on the scripting; this helps ensure consistency and avoids unnecessary confusion with the Medicare population.

➤ Delivery of the second message. Fitting the delivery of the second message into its busy routine has been a big challenge for Hake’s department.

“We needed to come up with an internal method for tracking and managing our compliance,” she said.

Because the department was already in the process of updating its CM form, it simply added a place for the care manager to document when the second IM was delivered.
“We would sign and date it, and it would be there for nursing and physicians and would become a permanent part of record,” Hake said.

**Education of nurses and physicians.** “Since care management assumes responsibilities for the second message; we were also responsible for training nurses and physicians,” Hake said. “We knew it had to be concise, consistent, and very brief.”

At a monthly nursing operations meeting in June, Hake gave nurses and weekend supervisors copies of the IM, training materials, and a revised CM discharge planning guide. She explained the history and the importance of the IM and walked them through the process, including the delivery of the first message if for some reason a patient wasn’t able to sign the IM on admission.

The department also decided to add the IM to orientation for all new nurses and agency nurses and to add signature and date to the admission and discharge forms, just as a further check to ensure that the forms are done in timely manner. One-on-one with care managers is a critical aspect of their training.

“It is probably the most important one with our physicians,” said Hake. “Our care managers are unit-based. We interact daily with our physicians, residents, interns, and med students. We discuss our patients and discharge plans; we’re the ones who are being very proactive, going to our physicians to talk about where and when this patient will be going at discharge.”

**Daily morning meetings.** The CM group also implemented a daily morning meeting to discuss all new admissions.

“We discuss all new admissions, length of stay, discharges for that day and the next day, any home-health referrals, and any discharge issues that any of our care managers are having,” Hake said.

They also print out a daily census that includes the patients’ insurance type, making it easy to identify their Medicare patients so they can make sure they are all contacted. They review all new patient admissions within 24 hours or the next business day.

**Compliance tracking.** The CM department asked what it could do to track compliance.

“We already do random chart audits through our QI department, and we felt this is the place to keep it,” Hake said. “Since all our charts are scanned, we’re able to view all the forms, and we decided a random audit process will reside in the quality department as do all the other audits. The charts will be reviewed for signatures [and for] the date on the IM and on the CM discharge guide; we’ll look for timeliness to admission and discharge and any progress notes that are there. We’re developing a process that does address compliance without placing an increased burden on any of the departments, and that is a big challenge.”

She said they will continue to monitor the process to determine what alterations need to be made.
My 2008 wish list
Hospital directors ask for a better year

If a genie appeared and granted you wishes for your healthcare facility for the New Year, what would they be?

Patient Access Advisor put the question to two directors in the revenue cycle: a patient access director in the New Orleans area, Fran Landry, and a patient financial services leader in St. Louis, Julie LaFrance, MBA. Here’s what they’re wishing for in 2008.

Fran Landry
1. I wish the communication between the areas of our department would be more efficient than it currently is. It seems we all get so busy that sometimes we tend to forget to relay messages or pass on information to each other. We spend quite a bit of time on the telephone so phone calls are difficult; we don’t always have time to check our e-mail throughout the day, and face-to-face communication is not always possible.

2. I wish we could hold refresher courses every month for our staff. It would be extremely beneficial to our staff to hold ongoing training to keep them up to date, as well as retraining about recurring errors. This is extremely difficult because it means having to pull registrars away from registering patients in order to have the department trainer meet with them to go over this type of information. With the patient volume, call-ins, and employees out on family medical leave, having the time for this type of detailed training is difficult.

3. I wish every member of my department had excellent customer service skills. Because everyone’s personality is different, customer service is not delivered the exact same way across the board. I would like to see some type of customer service training to outline how the patient should be handled from the beginning to the end of the registration process. Again, that takes additional training, and there are just not enough hours in the day to get everything done.

4. I wish the physician’s offices would follow our guidelines for completing orders properly and in a timely manner (or on time). The majority of the delays in our lobby are due to physicians’ offices not completing their orders properly or on time. We have done numerous education sessions with them to explain what we need and how we need it, but they always end up reverting back to their old ways. It is a never-ending battle of re-education.

5. I wish more insurance companies had online access to benefit information. Because our volume is increasing, it would be extremely helpful if more payors had online access to their enrollees’ eligibility and benefit information to expedite the pre-registration process. We do currently have access to some payors, but not all of them have the detailed benefit information that we need, so we end up having to make a phone call, which delays the process due to long hold times.

6. I wish for a better working relationship between Patient Administration System and the ancillary departments of the hospital. It would be extremely helpful for the ancillary departments to be educated about the registration process so they would have a better understanding of why we need the information we are asking for, and that a registration is not “just putting the patient into the computer.” There is so much more to the process than that, and it would be helpful if more people across the facility had that understanding.
7. I wish there were a better way to educate our patients about registration requirements. We currently educate our patients either on the telephone during the preregistration process or in person when they present on what they need to properly complete their registration process. It would be helpful to have this information on our Web site in the proper format for patients to understand. Some guidelines on best practices to get this accomplished would be extremely helpful.

8. I wish other areas of the department had the same sense of urgency that we do when taking care of our patients. It always seems that when we are in a situation with a patient when we need to expedite processes, the other areas that we are dealing with don’t seem to respond appropriately. We do what we can to emphasize the importance of the situation, but we do not always get the responses we are looking for.

9. I wish my department would get the respect it deserves from other areas of the facility. My department works extremely hard to do what is right for our patients in a positive and timely manner, but it just seems that whenever anything goes wrong with a patient, other areas of the facility try to find a way that the error can be blamed on registration. If everyone had a better understanding of the registration process, they would be more aware of what is expected of the registration department and possibly have a new appreciation for what we do every day.

10. I wish I could come up with different ways to reward my staff for a job well done. Due to budgetary constraints, it is not possible for the facility to include any additional increases other than performance evaluation increases. We do what we can ourselves to reward our employees with luncheons and thank-you cards, but we are always open to new ideas to increase the morale of our staff members and come up with new ways to show them how much we appreciate what they do every day.

Julie LaFrance

1. I wish there were one day that I didn’t have a “crisis” to deal with. (Come on. Let’s define “crisis.” What would you do if I wasn’t standing right next to you when the situation surfaced?)

2. I wish all insurance companies would process claims consistently within the timely filing guidelines.

3. I wish all remittance advices followed the exact same format and used the same abbreviations and codes.

4. I wish we could hold insurance companies accountable for losing requested documentation sent to them.

5. I wish physicians would be held financially liable for obtaining preauthorization of radiology services.

6. I wish all patients understood and took responsibility for understanding their benefits.

Editor’s note: LaFrance is director of Patient Financial Services at St. Joseph’s Hospital in St. Louis. She has 19 years of healthcare experience working in a variety of capacities. Landry has worked at the 451-bed West Jefferson Medical Center in Marrero, LA, for 22 years.

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In hindsight, it’s time to look forward
A reflection of one year and a plan for this year for two healthcare leaders

Better patient flow. A clearer understanding of one’s job description.

Those are among the best achievements in 2007 for two healthcare leaders. Dell T. Forrester, CPAM, director of patient financial services at Chester River Hospital Center in Chestertown, MD, and Brittany Evans, patient access coordinator at Harrison County Hospital in Corydon, IN, sat down with Patient Access Advisor for a conversation about 2007 and the New Year.

Here’s what they said.

Dell T. Forrester

PAA: What was your best achievement in 2007?

Forrester: The highest achievement in 2007 at Chester River was a major decrease in patient wait times. We have decreased wait time from an all-time high of 20 minutes to just less than four minutes.

To achieve our goal, we have several staff members assigned to preregistration and when the registrars have downtime, they also preregister our patients. A change in patient flow and staff assignments were key in reaching this goal. Interdepartmental communication and cooperation has reached an ideal level, another achievement in 2007.

PAA: What was one thing you wish you could do over and why?

Forrester: I don’t believe in looking at life and work, in general, that way. If results were not what we hoped to achieve, we regrouped and made the necessary changes.

PAA: What is your goal for 2008?

Forrester: We want to increase our level of customer service. At this time, we don’t collect any monies at point of service, and I want to change that in 2008.

Brittany Evans

PAA: What was your best achievement in 2007?

Evans: I believe it would have to be getting several policies in writing and making the registration clerks’ jobs easier by letting them know what is expected of them. By the end of the year, I should have an official policy manual for the department, which is huge since there has not been one in several years.

PAA: What was one thing you wish you could do over and why?

Evans: Starting a surgery policy too soon. The surgery department hadn’t fully tested the module, and when we started the policy I was under the impression they had, so it blew up in our face and made for lots of extra work all around. I should have suggested a test run through with me included.

PAA: What is your goal for 2008?

Evans: We will be moving into a new facility, so my goal is to update the area and diminish our out-of-date procedures. I would like to have one way to do things, not one way with 100 if, thens, and buts. So simplicity is my goal.

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2008 OPPS final rule a radical change, sources say
OPPS' packaging concept explodes

The 2008 OPPS final rule marks the first occasion in which hospitals have seen a radical change to packaging and other methodologies to control rapidly growing healthcare expenditures under the OPPS, says William L. Malm, ND, practice director of revenue cycle management at HCPro, Inc., in Marblehead, MA.

CMS released the 2008 OPPS final rule (CMS-1392-FC) on November 1, 2007, and it takes effect January 1. In addition to finalizing most of its proposals, CMS created a new type of APC in the rule—a composite APC—that in certain circumstances provides a single payment to cover services across the entire patient encounter.

“This final rule appears to contain the most radical changes to OPPS payment policy since its inception in August 2000,” says Jugna Shah, MPH, president of Nimitt Consulting in Washington, DC. “Some of the changes are understandable regardless of whether they will be positive or negative for hospitals, but others are radical and raise the question of what pressures CMS was facing that caused it to move forward with so many significant changes all at once.

Medicare’s packaging rationale

Wholesale packaging came as no surprise to Valerie Rinkle, MPA, revenue cycle director for Asante Health System in Medford, OR. “Without explicitly being able to articulate that wholesale packaging was on the horizon, I knew that Medicare was going to have to do something once they came out and said that they were going to use APCs for ambulatory surgery centers [ASC],” says Rinkle.

In order to level the playing field and have the APC system work for ASCs and hospitals, Rinkle knew that Medicare would have to do something drastically different—and it did.

“What they chose to do was to package absolutely as much as possible into APCs, so that the ASCs still bill the majority of services with just the surgical CPT codes,” Rinkle explains. In the past, ASCs could only bill for surgical CPT codes and no other incidental CPT codes (e.g., radiology, respiratory), which, when compared to hospital reimbursement for a similar encounter, is very little.

Meanwhile, hospitals can bill surgical CPT codes along with other supportive CPT services, such as guidance imaging and respiratory care. Rinkle notes that if hospitals provide any other separately identifiable services (following CPT coding rules), they can bill and be reimbursed for those other incidentals.

“I think that the cost containment mentality is the secondary rationalization, says Rinkle. “I think the first rationalization is making the system work for ASCs and hospitals.”

Shah agrees with Rinkle, but also wonders how much of a driver the ASC issue really is given that CMS continues to allow ASCs to bill on a different claim form and continues to maintain payment and coverage site of service differentials between the ASC and hospital setting, the ASC and the physician setting, and most notably between the hospital and the physician setting.

“If CMS really wanted to level the playing field, it would make different decisions and not just implement policies like wholesale packaging that are likely to impact OPPS providers more significantly than ASCs, since hospitals will lose reimbursement on all cases where the dollars for the newly packaged services are not appropriately reflected in the APC payments for other services,” says Shah.

Incorporating ASCs into the APC system may have an effect on Medicare’s APC calculation down the road, Shah says. In the final rule, Medicare said that it would examine whether ASCs should use the UB-04 form as opposed to the CMS-1500.

“I think that would be very interesting if Medicare makes that change, because then the question becomes, will CMS roll in the ASC [claim and cost] data into calculating APCs?” Rinkle asks. “CMS claims it’s trying to level the playing field and make it less and less of a > continued on p. 8
differential based on payment. Of course, some of these changes would require legislative changes because many of the payment rate calculation formulas are fixed in law.”

**Broad packaging of services**

Both Shah and Malm point out that CMS stayed the course with its proposed packaging proposal despite the comments received from providers, industry leaders, and trade associations. CMS is moving forward with expanded packaging in each of the following categories:

- Guidance services
- Image processing services
- Intraoperative services
- Imaging supervision and interpretation services
- Diagnostic radiopharmaceuticals
- Contrast media
- Observation services

By expanding its packaging logic, CMS will no longer pay hospitals separately in 2008 for a large number of services for which hospitals currently receive separate payment.

“I’m definitely surprised at how much of a hard line CMS has taken given all of the comments, including the recommendations from the APC Advisory Panel,” Shah says.

Packaging isn’t necessarily a bad idea, she says, but CMS’ wholesale packaging introduction in such a short time “is too much” and has left industry and providers wondering about the accuracy of the calculations, particularly in cases where the logic doesn’t “smell right.”

For example, if a provider today bills two line items and receives two separate APC payments totaling $1500, but in 2008 will receive only $800 for the same two billed line items because one is now packaged, “it’s pretty clear something is not quite right with CMS’ calculations related to the packaging logic,” she says. “The rapid movement and expansion of the packaging policy apparently reflects CMS’ goals of controlling outpatient expenditures and volume, even more so than moving toward value-based purchasing or trying to streamline payment policies between hospitals and ASCs.”

You can find a complete list of all packaged HCPCS codes that fall into the seven packaged categories in Table 10 on p. 313 of the OPPS rule. This table indicates whether a code has a status N (packaged services) or Q (packaged services that are subject to separate payment under certain OPPS criteria).

**Diagnostic radiopharmaceuticals**

Note that on p. 249 of the final rule, CMS finalized the decision to package all diagnostic radiopharmaceuticals, despite the comments it received against this proposal, including the APC Advisory Panel’s recommendation.

The APC Advisory Panel recommended continuing separate payment for diagnostic radiopharmaceuticals greater than $200. CMS did not elect to adopt this and instead will package all diagnostic radiopharmaceuticals. This is likely to have a significant financial effect on hospitals that provide specific nuclear medicine procedures.

The one positive change for providers in this area is that CMS will implement edits in the Medicare outpatient code editor for nuclear medicine services furnished on and after January 1 to look for claims submitted without a HCPCS code or the charge for a diagnostic radiopharmaceutical. Shah notes that this is a positive step as it will allow providers to fix their claims and ensure CMS has complete data for future rate-setting.

**Separately payable drugs, pharmacy handling**

On p. 721, CMS finalized its proposal to pay for most separately payable drugs at the average sales price (ASP) plus 5%, which is a 1% reduction from current payment policy. In addition, CMS backed off of its proposal to require hospitals to report pharmacy handling/overhead costs separately.

“This is a mixed bag of news; providers are likely relieved that CMS did not move forward with its original
Copay collection: Better transparency with patients and dollars saved

Collecting copayments will not make hospitals rich. “Collecting copays up front doesn’t really do much when it comes to helping cash flow, because those amounts can be fairly low,” says T. T. “Mitch” Mitchell of T. T. Mitchell Consulting, Inc., in New York City. “If you include deductibles, then you’re starting to possibly make some big differences when it comes to cash.”

However, there are benefits to increasing your facility’s copay collections.

It can save on billing expenses and also save headaches for patients who do not want random bills showing up on their doorstep months after their hospital visit.

“It eliminates the decision whether to write off accounts or send them to collections, and it actually improves patient relations because patients aren’t getting those self-pay bills months late when insurance companies sometimes take a long time to pay the hospital,” Mitchell says.

Mitchell suggests two strategies for collecting the money up front:

1. Make sure every person who’s allowed to collect payments knows all the contracts and the payment amounts for all insurances

2. Except for emergency admissions, make sure that every contact with a patient before he or she comes to the hospital includes the consistent message that payment will be expected before services are provided

“Actually, hospitals should make sure all physicians who may send patients to the hospital know this, since the physician offices are doing the same thing, so that no one is shocked or upset if they happen to show up at the hospital without speaking to someone at the hospital first, which happens most of the time unfortunately,” Mitchell adds.

See p. 10 for a form about copayment collection from HCPro, Inc.’s book Hospital Auditing and Monitoring Toolkit: Sample Programs for Key Risk Areas.
# COPayment COLLECTION

<table>
<thead>
<tr>
<th>Location:</th>
<th>Auditor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Module:</td>
<td>Actual Hours:</td>
</tr>
<tr>
<td>Budget Hours:</td>
<td>Signature:</td>
</tr>
</tbody>
</table>

**Objective:** To ensure that the organization maximizes collection of copayments.

At the end of each numerical section, a "Comments" area has been included where all "No" disclosures must be documented.

| 1. Review the process for determining when to send patients to the business office for financial arrangements, including payment of deductibles and coinsurance. Do this by meeting the staff in the department being audited. This will allow you to develop a strategy and an audit that applies to their departmental needs. |
|---|---|
| Comments: | Yes* | No | N/A |

| 2. Identify what measures the hospital has created to demonstrate a good-faith effort to comply with Medicare billing rules for outpatient services rendered in connection with an inpatient stay. Include measures taken to comply with the 72-hour bundling rule. |
|---|---|
| Comments: | Yes* | No | N/A |

| 3. Determine whether all registration areas have access to current preferred-provider organization or health maintenance organization (HMO) contracts. |
|---|---|
| • If not, determine how patient-registration representatives ensure that the proper insurance plan and financial class are associated with each patient registration. |
| • Check for procedures to deactivate expired contracts. |
| Comments: | Yes* | No | N/A |

| 4. Check screening services against the OIG’s screening-waiver policy. |
|---|---|
| • Read the OIG’s advisory opinions on waiving copayments and deductibles, and compare these situations to the organization’s business arrangements. |
| • Determine whether registration staff members always ask to see the patient’s insurance card. |
| • Review automated insurance-verification processes and policies, if applicable. |
| Comments: | Yes* | No | N/A |

*When appropriate, check "Yes" to indicate that the task is complete.

**Sources:** Brian Kozik, director of compliance and audit services for the North Shore Medical Center in Salem, MA, and Hank Vanderbeek, MPA, CIA, CFE, a healthcare consultant from Haverhill, MA.

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Illustration by
David Harbaugh

“I hope you don’t mind, but the ER is overcrowded, so you now have 45 people in your waiting room.”
Sample care management form

Care Management/Discharge Planning/Referral Guide

Check if applicable
- Suspect child/adult abuse
- Receiving home health services prior to admission
- Admitted from ECF, Rehab, or supervised living arrangement
- Homeless
- Diagnosis of alcoholism, drug addiction/abuse or overdose
- Patient on Medicare (Medicare alone does not indicate referral)
- Dependent ADL, lives alone, no identified caregiver
- End of life/Hospice issues effecting discharge process

If total greater than 1 or Medicare plus 1, patient referred to Care Management

Check if applicable
- History of nonadherence to medical/surgical plan
- Pain management problems
- Complexity of diagnosis
- Multisystem failure
- 2 or more related admissions within 1-3 months
- Readmission within 24 hours of discharge
- Select diagnosis - Congestive Heart Failure, Diabetes, CVA, MI, Orthopedic surgery
- Chronic condition with exacerbation
- Psychiatric co-morbidities effecting discharge process
- 70 years of age or older

If total greater than 1 or Medicare plus 1, patient referred to Care Management

- Follow-up not necessary unless situation changes

__________________________  _______________________
Signature of Care Manager  Date

IM/Discharge Notice given to Patient

__________________________  _______________________
Signature of Care Manager  Date

Memorial Hospital

953001
6/07 jlf
Tab: Progress Notes

Source: Memorial Hospital in York, PA. Reprinted with permission.