



**The Importance of Documentation and Leveling in
the
Good Samaritan Hospital
Emergency Department
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Charlotte L Kohler,
[RN], CPA, CVA,
CPAM, CPC, CHBC

443-956-1434

CharlotteKohler@Comcast.net

Objectives of This Session

- To understand the purpose of good documentation for patient care, maintaining licensure, and proper charging
- To introduce new forms and the related Policy & Procedures
- To discuss the severity of the patient population in the GSH ED – based on what is being charged
- To understand the nuances of charging requirements.

Key Concept #1

Patients present to the ED because

- It's needed for the level of care/condition
- It's convenient
- It's a habit

Emergency Services are “no appointment”, no “scheduled” care which should be urgent or emergent in nature.

Payers want to reduce payments for ED care.

Key Concept #2

Patient care is upmost and documentation is for:

- Appropriate care of the patient and coordination by care givers
- To support care if challenged (malpractice and licensure)
- To properly charge patients for resources used

We want to charge patients appropriately based on the intensity of their service received – this includes “DIRECT” and “INDIRECT” time.

Direct and Indirect Time

Direct – with and for the patient

Indirect – on behalf of a specific patient

Some of the areas that may be obvious: coordinating care, retrieving drugs and supplies for patient

Some not so obvious: coordinating care to another facility, after death care and coordination.

What other examples can you think of?

Key Concept #3

How we charge is based on CCT, but it may help to think about....

- Triage Level is the opposite of Service Level
- Level 1 and 2 – Patient should have gone to their doctor's office
- Level 3 – May have been able to treat at the doctor's office
- Level 4 and 5 – Should be in ED, and all admissions should be at 4 or 5.

What Does the Current Intensity Look Like at GSH ED? (Using 1/2009 Charges)

	<u>Visits</u>	<u>%</u>
Level 1	120	3%
Level 2	1748	38%
Level 3	1483	32%
Level 4	1064	23%
Level 5	145	3%
Follow Up	83	2%
Total	4643	100%

Key Concept #4

ED Physician billing is not the same as GSH ED facility charge

- No Charge – maybe not for the professional provider....
- Wound checks – It really a “check”?
- Suture Removal – not charged by doctor put in sutures, but suture removal charged by any other physician.

WHY are ED Services Different from Other Nursing Services?

Clinical Care Time (CCT) is how resources are measured.

Resources= all ED staff (and benefits), supplies not separately billed, heat, light, electric, equipment, overhead of hospital allocated to ED.

EVERYONE in the ED Staff Counts!

- Each person's time counts when it relates to patient care and CCT – caveat: who is not billing separately from another department
- Consider time for those not charging separately for their services – pastoral care, psych evaluations, social workers
- Dilemma is how do “we” know? Does the documentation clearly identify how many provided care?

Level = \$.....BUT

- Items of confusion:
 - EKG
 - Respiratory Services
 - Patient Admitted – but still here
 - Patients to be transferred ... we're starting a way to recover revenue for our efforts! It's called "Extended Care Services"

Tools to Help You Succeed

- New “leveling form” → Now called ***Clinical Level of Care Form***
 - Was incomplete
 - Was not set up clinically
- No written policy or procedure to explain the meanings – and to use as a reference.
- Need for training
 - Create “level playing field”
 - Opportunity to discuss issues and concerns from those who will be using the form.

The New Leveling Form

- Time – stated
- Time – if blank → ADD
- If “Star” → requires a sticker or another form



Supplies

List being updated

Look for charges – you are the only person who knows.

Extended Care Services – NEW!!!

Helps to recover revenue for the patients who are to be transferred to **another facility (Requirement #1)**, and who have reached **Level 5 in Charge Level (Requirement #2)**.

Can not exceed 48 hours (per HSCRC).

Calculated on clock time (hours, rounded ***DOWN***) – time starting when the doctor writes the order to transfer.

Examples to Calculate ECS

Patient to be transferred to Union Memorial

#1 Order for transfer at 1030

CCT at 1030 = 130 minutes

Actual transfer at 1526

#2 Same Order; CCT at 1030 is 110; transfer at 1526

#3 Same Order; CCT at 1030 is 110; transfer at 11:45

Understanding These What Mean to You for Leveling

- LWBS – Triage Only
 - ➔ Record care provided but we can only charge the “Triage Only”
- AMA
- AWOL
- Re-Check
 - ➔ Record care provided and count CCT to whatever level

Overall Comments from Our Review

1. Generally, documentation was good – we found examples of excellent documentation and some that needed improvement
2. It is not possible to tell who (and how many) provided care – could be a problem in both malpractice/licensure and billing
 - Codes
 - Conscious sedation
3. Signoff for orders and medication reconciliations not always adequate (The “Done Syndrome” and “Who Was That Anyway Fever”)
4. Transport of the patient – documentation needs to be more comprehensive
5. When there should be multiple care givers it needs to be documented – we can’t assume! It only takes a few words

Good Samaritan Hospital (by
KHC)

Overall ED Considerations

Do Sweat the Small Stuff.....

..... Patients and their insurance companies look at the documentation to support the services being provided

..... Look for trends and identify questions or issues needing future clarification.