

	HOSPITAL DIVISION FINANCIAL POLICIES and PROCEDURES MANUAL	
	SECTION 2.0 – PATIENT ADMISSIONS	

2.4 Admissions – General Information

Patient Classification

- **Inpatient**
An **inpatient** is a person who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as a patient with the expectation of remaining at least overnight and occupying a bed, even though the patient may be discharged or transferred to another hospital and not actually use a hospital bed overnight.

- **Outpatient**
An **outpatient’s** classification is determined by the patient’s physician. The patient will be admitted as an outpatient in Meditech and receive services (rather than supplies alone) from the hospital.

If a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital less than 24 hours, the patient is considered to be an outpatient for coverage purposes (regardless of the hour that the patient entered the hospital, whether the patient used a bed, or whether the patient remained in the hospital past midnight).

a) Types of hospital outpatient services:

- Services that are diagnostic in nature (e.g. laboratory and imaging)
- Outpatient surgery
- Occupational, physical, speech and respiratory therapies
- Wound care
- Other services which aid physicians in the treatment of patients.

b) Definitions of Meditech Outpatient Routine Designations

- **Clinical (CLI)** Used for those patients receiving outpatient ancillary services such as laboratory tests, x-rays or blood tests.

- **Recurring (RCR)** Outpatients basis receiving a series of treatments such as physical therapy, occupational therapy, speech therapy, chemotherapy, and wound care.
Meditech Recurring Admission Training Guide

- **Emergency (ER)** Patients treated in the emergency room.

- **Surgical Day Care (SDC)** Patients admitted to the hospital for same-day surgery.

- Referred (REF) Patients receiving outpatient services used for client billing (industrial accounts).
- Observation (Ino) Observation patients are assigned a room and bed, but do not receive automatic room/bed charges (Note: this level shall not be assigned prior to assessment by case management).

2.5 Patient Admissions

The Admission Routines allow the Admissions Clerk/designee to admit patients to the hospital through the Meditech Admissions function and to create ProTouch□ registrations.

a) Apache Scoring

Admissions with a Meditech admission source of '4' (Transfer from Hospital) require an Apache score. The clinical pre-assessment information shall be entered into Meditech, generating an Apache III score. The Apache score is a predictor of acuity and LOS (Length of Stay) for critical care patients. For all other admissions, an Apache score *shall not* be obtained.

If the system does not return an Apache Score when requested, verify the following fields are complete: date of birth, temperature, GCS (Glasgow Coma Score) medications, SBP (Systolic Blood Pressure), DBP (Diastolic Blood Pressure), heart rate, ventilator status, respiratory rate, and referral date. Eyes, motor, and verbal fields are required if the GCS Meds field is marked "Yes." Complete the admission and re-calculate the Apache Score through the Meditech Inpatient Admissions Edit or Pre-Admit Routine

b) Account Number Assignment

Account numbers (unit number, medical record number) are not assigned for new patients when completing Apache Scoring. Instead, the automated Master Patient Index (MPI) in Meditech should be used to search for a prior stay/episode at the unit number prompt. If the referred patient has a previous stay/episode, the automated process in Meditech should be used to select the patient so that the same unit number (medical record number) may be assigned.

If a patient is selected from within the MPI, the patient's previous demographic information will be pulled into the referral fields, reducing time for entering the referral. The Admissions Clerk/designee shall verify data fields, and edit prior stay demographic information, when necessary.

Meditech assigns a visit-specific account number once all required fields are completed.

c) Completing Admission Forms

- Explain all benefits to the patient or responsible party upon admission
- Document this explanation on the documents scanned into the VPF.
- Ensure that *all* fields are completed on admission documents and that the documents are signed by the patient/representative upon admission.
- Notify Controller/ designee when signatures cannot be obtained and document reason.
- Ensure that Advance Directive information follow-up items are noted and tracked to completion.

- Attach the applicable admission forms to the patient's medical record and scan all documents into the Virtual Patient File Folder as indicated on the Admissions Document Checklist.

All patient admissions and registrations will be completed using the procedures outlined in Section 2.5 with the following exceptions.

a) **After Hours Admission**

When Admissions Clerk/designee is not available, the Nursing Supervisor/designee shall register the patient in Meditech through the After Hours Admission Routine to create the ProTouch registration and allow for immediate medical record documentation.

b) **Meditech Downtime Procedures**

The Admissions Clerk/designee shall perform admissions in the event of Meditech system downtime using the Virtual Patient File Folder downtime forms routine.

2.6 Admission Documents

The Meditech Admissions Package contains all required forms specific to a facility. Additional optional forms are also available and can be printed upon demand from the Virtual Patient File Folder.

Virtual Patient File Folder (VPFF)

The Virtual Patient File Folder (VPFF) allows users to access all Admission Documents, as well as other financial documents from a central location. All documents generated out of Meditech print with a bar code at the bottom of each page. All admission documents, including the PACE, Insurance Verification, and Insurance Card must be scanned into the folder. In addition, all forms shall be printed from the VPFF.

For work instructions and access to the VPFF go to: Knect – Hospital Division – CBO Patient Financial Folder.

a) Required Inpatient Forms:

- Admission Face Sheet
- Admission Agreement (includes Consent to Treat)
- Patient Rights and Responsibilities
- Alternative Dispute Resolution (ADR) Agreements - Alternative Dispute Resolution is a voluntary program that permits patients or their authorized representative to obtain faster resolution to any disputes (including quality of care or billing issues)
- Organ Donor Consent Forms (Utilize only if required by State law):
- Anatomical Gift by a Living Donor
- Anatomical Gift by Next of Kin or other Authorized Persons
- Advance Directives - Form should be utilized by the Social Service Manager/designee to ensure the patient has necessary information and assistance to establish an advance directive if desired. Follow-up action is required to obtain copies of Advance Directives identified on this form (See State specific guidelines).
- Your Right to Decide
- Statement of Ethical Policies
- Notice of Privacy Practices

- Designation of Individuals Authorized to Receive PHI
 - Important Message from Medicare/Champus – (Medicare only - see note below)
 - Medicare Secondary Payer Questionnaire – (All potential Medicare patients - see note below)
 - Election Not to Use Lifetime Reserve Days and document on the Admission Checklist – (Medicare only - see note below)
- Request for Insurance Policy/Letter – (see section 2.8 below)
- Valuables Statement – (see section 2.10 below)
 - Admission Document Checklist. (Hospitals may determine it sufficient to obtain the patient’s signature on the checklist and the patient’s initials on all forms listed on the checklist.)
 - Pre-Admission Clinical Evaluation (PACE) Form

b) Additional Resource Forms available within Meditech:

Emergency Contacts

- Revocation of Election Not to Use Lifetime Reserve Days – (see note below)
- Anatomical Gift
- Cafeteria Ticket
- Authorization and Consent for Surgery (some state specific)
- Refusal for Medical Care (some state specific)
- Revocation of Alternative Dispute Resolution

) Explanation of additional forms required for Medicare patients:

- Inpatients - An Important Message from Medicare/Champus - This form shall be given to the patient within 2 calendar days of admission and be signed by the patient/representative. A follow-up copy of the form signed at admission shall be given to the patient within 2 calendar days of discharge. This form requires the address of the state Quality Improvement Organization (QIO) be pre-printed. It is the responsibility of the DQM / Admissions Clerk to ensure that this information is accurate..
- All patients - Medicare Secondary Payer Questionnaire - Medicare regulations require the hospital to obtain information on possible Medicare secondary payor situations. Also see Section 6.2 “B” Medicare Part A – Specific Instructions.
- Inpatients - Election Not to Use Lifetime Reserve Days. The Admissions Clerk/designee is required to notify patients who have already used, or will use, 90 days of benefits in a spell of illness that they can elect not to use reserve days for all, or part of, the stay. Lifetime Reserve Day use is generally in the beneficiary’s best financial interest and thus the patient is “deemed” to have chosen to use these days unless they make an affirmative election to not use this benefit. If a patient elects not to use Lifetime Reserve Days, the Election Not to Use Lifetime Reserve Days Form shall be completed and maintained in the patient’s financial folder.

A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a state plan shall be advised that such assistance will not be available if the beneficiary elects not to use Lifetime Reserve Days.

Medicare Supplement plans may also require the beneficiary to use all Lifetime Reserve Days before the plan coverage begins.

- Inpatients - Revocation of Election Not To Use Lifetime Reserve Days – Use this form only when a Medicare beneficiary who previously elected not to use Lifetime Reserve Days desires to revoke that election.

d) Required Outpatient Forms

- Patient-specific face sheet
- Admission Agreement (includes Consent to Treat)
- Patient Rights and Responsibilities
- Alternative Dispute Resolution (ADR) Agreement - Alternative Dispute Resolution is a voluntary program that permits patients or their authorized representative to obtain faster resolution to any disputes (including quality of care or billing issues). See State specific guidelines.
- Advance Directives - Form should be utilized by the Social Service Manager/designee to ensure the patient has necessary information and assistance to establish an advance directive if desired. Follow-up action is required to obtain copies of Advance Directives identified on this form.

2.7 Admissions Documentation Audit

The CBO shall review three (3) inpatient and three (3) outpatient (where relevant) financial folders on a monthly basis to ensure admissions documentation is adequate. Evidence of this review shall be documented and retained.

2.8 Request for Insurance Policy

The patient and/or family members shall be requested to provide the hospital with a copy of the patient's insurance policy, whether a supplement to Medicare or any other insurance which the hospital is to bill. The hospital may prepare, in advance, a form letter (to be signed by the patient or authorized representative) requesting that a copy of the patient's insurance policy be mailed directly to the hospital from the insurance carrier for billing purposes.

The Admissions Clerk/designee shall document all attempts to obtain copies of the patient's insurance policy, insurance card, and other insurance information in the patient's Meditech notes. If the patient is unable to provide a copy of the primary or supplemental insurance policy, the request for policy letter (provided that it bears the signature of the patient or authorized representative) will permit the CBO/designee to obtain a copy directly from the insurance carrier. If the above information cannot be obtained, the CBO/designee shall notify the CFO/Controller.

The hospital is not required to obtain copies of insurance policies for Medicaid, established managed care contracts or outpatients.

2.9 Patient-Specific Contracts

If upon initial insurance verification of a prospective admission, an insurance company requests a discount from verified benefits, the CFO/Controller/Managed Care Representative shall be responsible for negotiating the patient-specific contract. Additionally, any subsequent "Letter of Agreement" shall be prepared and controlled by the CFO/Controller.

A patient-specific “Letter of Agreement” may be created under the following situations involving a non-contracted insurance company requesting a discount from the payment methodology identified in the verification of benefits:

Example 1: Acute benefits are verified at 100% of all billed charges, but the insurer requests a discount.

Example 2: Acute benefits are verified at a percent of charges, but the insurer requests a per diem rate.

Example 3: After admission, the patient moves to different level of care (ICU to Med/Surg) and the insurer requests a different rate.

All patient-specific “Letters of Agreement” should contain language covering the following areas:

A. Reimbursement:

The CFO/Controller/Manager Care Representative shall negotiate the reimbursement terms. The preferred order is:

- 1) Percent of billed charges
- 2) Per diem plus exclusions and stop-loss provisions
- 3) All-inclusive per diems and stop-loss provisions

B. Level of Care:

The Admissions Coordinator/Clinical Liaison shall inform the CFO/Controller as to what level of care (e.g. ICU, Med/Surg or Acute Rehab, subacute, etc.) the patient will be admitted.

C. Inclusions / Exclusions:

List of specific hospital services to be provided and reimbursement for each excluded item. References to AWP (Avg. Wholesale Price) cost plus mark-ups should be avoided due to complexity in administering and billing.

D. Stop-Loss Language:

Protection from financial loss due to medically complex patient.

Example:

Switch from per diem to percent of billed charges for all billed charges exceeding a certain charge threshold.

E. Prompt Payment:

Expected number of days for an insurance company to pay a bill before payment of total billed charges required.

Suggested Guideline:

If payment under this arrangement is not made within 30 days after receipt of claim, the above-mentioned discounted rate shall be forfeited and full payment is required.

F. Execution of Letter of Agreement:

The Letter of Agreement shall be signed by the CFO/Controller/designee and forwarded to the insurer (via mail or fax) for execution. The fully executed Letter of Agreement shall be stored in the VFFF.

G. Terms of the Letter of Agreement should be documented in Meditech and the CBO should be made aware a Letter of Agreement was executed.

H. The CBO shall input the patient specific contract in Meditech.

I. Insurance Mnemonics:

If a new insurance mnemonic is required for setup in Meditech, the Insurance Mnemonic Contract Request Form shall be completed and sent directly to the Regional Senior Director of Patient Accounting for approval. Pending approval, the Regional Senior Director of Patient Accounting will forward the request to the Managed Care Department for assignment of the managed care organization code (MCO) and to the email group 'IS-FSD Patient Accounting' for creation in Meditech. Please note that facility personnel will no longer need to call the help desk to open a ticket. Once the insurance mnemonic is complete or if there is an issue with the form, the Meditech Group will notify facility personnel.

2.10 Medicaid Eligibility/Application Process

The Director of Case Management/designee shall facilitate the Medicaid application process, and the family is responsible for completing state-specific financial disclosure forms for medical assistance eligibility.

2.11 Patient Valuables

Patients should be discouraged from bringing valuables into the hospital. Valuables should be placed with family members upon admission. If no family members are present, valuables should be inventoried by at least two hospital employees on an inventory form (item by item) and placed in a secure location approved by the CFO/Controller. The original copy of the inventory form shall be signed by the persons performing the inventory
2.11 Patient Valuables (Contd.)

and placed in the patient's medical chart, indicating items are being held at the patient's request. A copy of this form shall be given to the patient or responsible party, with another copy of the form accompanying the valuables.

All valuables must be returned upon the patient's request. The patient/representative shall sign the inventory form, indicating the valuables are received/returned. (Copy shall be maintained in the patient's records). State guidelines must be followed when returning valuables.