MODERATE SEDATION PRIVILEGES STUDY GUIDE

The following Study Guide is provided for physicians eligible to apply for Moderate Sedation at LLUMC. The Study Guide is approximately 74 pages, so you may consider printing only the Test and reviewing the appropriate Study Guide on-line.

Once the test has been completed, fax only the test pages to Medical Staff Administration at (909) 558-6053 or extension 66053. A certificate will be issued for the sedation privilege(s) upon successfully passing the test. Please ensure all information is completed at the top of the test(s).

KIM The Medical Center's Knowledge-Based Information Menu from the Jesse Medical Library & Information Center (JMLIC)

in cooperation with **Information Systems** and hosted by **Telecommunications.**

P.U.R.P.L.E.

Physician's Unified Required Periodic Learning Exercise

for Loma Linda University Medical Center

- Advance Directives
- Autopsy Requests
- Confidentiality Laws
- Corporate Compliance Plan
- Electronic Patient Record System
- Emergency Medical Treatment and Active Labor Act (EMTALA)
- Fraud and Abuse
- Information Security and Confidentiality
- Informed Consent Process
- Patients Rights
- Preventing Sexual Harassment in the Work Place
- Procedure Related Sedation and Analgesia
- Restraints and How to Order
- Rules and Regulations Synopsis
- Smart Tips (JCAHO Preparation for Physicians)
- Teaching and Evaluating Medical Students
- P.U.R.P.L.E. Book Questions
- Fraud and Abuse Test Questions

KIM HOME VIP Home

If you have comments or suggestions for this page, please email: rhills@ahs.llumc.edu
Last updated April 12, 2001

ADVANCE DIRECTIVES
AND LIMITATION OF TREATMENT ORDERS

An ADVANCE DIRECTIVE or Advance Health Care Directive (AHCD) is a document generated by and signed by the patient only; never a family member or a physician. It may appoint another person to be the patient's health care "agent," or contain the health care wishes of the patient. All patients are asked upon admission if they have an advance directive and if they do, they are asked to provide a copy. When provided, this copy should be placed intact into the patient's chart, usually in the legal section. Other names of documents used by patients for their Advance Directive are "living will" and "durable power of attorney for healthcare." They serve the same purpose as an AHCD and are usually still valid if they reflect the patient's current wishes.

Effective July 1, 2000, California's Health Care Decisions Law made it easier for individuals to make their preferences known through written and oral communication. An individual may orally designate a surrogate/agent to make health care decisions. This designation is effective only during the current course of treatment, illness, or hospital stay. This oral designation of a surrogate/agent supersedes a previous written directive. Another new component of the law allows the competent individual to assign decision making to others and may state who is not to be allowed to make healthcare decisions.

A LIMITATION OF TREATMENT ORDER (including a DNR order) is a physician's order, which is generated and signed by a licensed physician only; never by a patient or family member. This is an official physician's order, just like an order for nursing care, medication, etc. The order is a separate and distinct statement in the physician's orders, not to be confused with the Limitation of Treatment progress note mentioned below.

The appropriateness and content of Limitation of Treatment (LOT) orders may be decided based on: (a) a conversation with the competent patient, (b) an understanding of the patient's written advance health care directive, (c) a patient surrogate/agent's reporting of the patient's previously expressed wishes, (d) a patient surrogate/agent's understanding of the patient's values, or (e) a patient surrogate/agent's assessment of what is in the patient's best interests. The "Directive for Life-Sustaining Intervention Progress Note" is the physician's documentation of these assessments and discussions.

Just because a patient has an advance health care directive does not automatically mean that LOT orders should be written. A patient may have a Living Will which says "If I am terminally ill and imminently dying, do not use heroic measures to prevent death." If that patient were admitted for an elective cholecystectomy, LOT orders would be inappropriate. If that same patient is admitted with terminal cancer, LOT orders may or may not be appropriate, depending on discussion with the patient or surrogate regarding whether it is time to invoke those conditions.

Just to add to the confusion, there is another form which is sometimes confused with both of the above, but it is actually neither one. This is the PHYSICIAN'S DOCUMENTATION OF PREFERRED INTENSITY OF TREATMENT form (often called the "PIT form"). It is used by nursing homes and other long-term care facilities at the time of admission to help establish goals of treatment and to make plans about the use or non-use of particular modalities, e.g.,

resuscitation, transfer to hospital, feeding tubes. It is meant to be completed by the attending physician, so it is similar to the LOT orders discussed above. It is sometimes incorrectly given to the patient or surrogate to fill out, or may even be completed by the nursing home admissions clerk or social worker. Nursing home staff and hospital staff alike often refer to this PIT form as an "advance directive," but it is not. It does not have the same legal weight as AHCD.

Do not hesitate to call the Clinical Ethicist on call if you have other questions or if you need assistance in clarification of any of these forms for a particular patient.

THE AUTOPSY

The autopsy plays an important role in completing the circle of medical care at the end of life, especially in a teaching and tertiary care center, such as LLUMC. The autopsy serves a number of important functions, including teaching, advancement of medical knowledge, detection of unexpected consequences of new therapeutic interventions, and monitoring of the overall quality of care and accuracy of various diagnostic modalities. As such, the autopsy is an integral part of the overall Medical Center's Quality Management program. Thus, although one usually thinks of the autopsy primarily as a means of determining the cause of death, it remains potentially useful even when the cause of death is readily apparent.

Obviously, patient's families cannot be compelled to provide consent for autopsy, but it is important to continue to request autopsies on patients who expire, both to confirm presumably established diagnoses and to evaluate any unresolved issues. Medical Staff and house staff can help improve our autopsy rate to that befitting an academic institution by:

1) Requesting consent for autopsy in a positive manner;
2) Letting the family know that there is no charge to them or their insurance for the autopsy; and
3) Informing families that the autopsy procedure does not interfere in any way with the suitability of the body for viewing at a funeral.

Also remember that, even if the family refuses to allow a full autopsy, they may still consent to a limited study to address specific problems, e.g., "chest only", or "don't examine the brain." Those restrictions can be stated on the consent form and will be honored by pathology staff.

When autopsy consent is obtained, fill out the yellow autopsy request form in the "death pack" available on the units. This is the place to convey your specific concerns regarding the patient, distill a one paragraph patient history, and indicate which physician or physicians should receive a copy of the report. A phone call to the Pathologist on call for the day can also be very useful in conveying specific concerns or questions regarding the deceased patient. Pathology Department attending staff are always available to discuss any further questions or concerns you or your patient's family may have regarding the autopsy.

CONFIDENTIALITY LAWS

STATE LAWS

As of January 1, 2000, three bills became effective as signed by the Governor of California and were later adopted as Civil Code that significantly affect the confidentiality of medical information. They are as follows:

SB19
- Providers of health care may not share, sell, or otherwise use any medical information for any purpose not necessary to provide health care services to the patient, unless expressly authorized by the patient or otherwise permitted by law;
- Medical information must be disposed of or destroyed in a confidential manner;
- Person who discloses medical information not permitted by law will be penalized up to $250,000.

AB416 Psychotherapists are prohibited from releasing outpatient psychotherapy without a special written request.

AB435 A patient's HIV information shall not be disclosed or used in an industrial injury or worker's compensation claim without prior authorization of the patient.

These laws refer to all members of the medical staff and to all employees. No one is exempt from following the provision of the laws. Violation of SB19, which results in economic loss or personal injury (such as embarrassment) to a patient, is punishable as a misdemeanor. In addition, a patient whose medical information has been used or disclosed may recover compensatory damages, punitive damages up to $3,000, attorneys' fees up to $1,000, and costs of litigation.

To learn more of the new state laws regarding the confidentiality of medical information, go to www.leginfo.ca.gov, click on "Bill Information," and then enter the number of the bill you wish to review. You may also contact the Medical Center's Health Information Management Department.

FEDERAL LAW

The Health Insurance Portability and Accountability Act of 1996 (HIPAA and also referred to as the Kennedy-Kassebaum Act):
- Mandates standards for electronic data interchange (EDI) and code sets;
- Establishes uniform healthcare identifiers; and
- Seeks protection and security of patient data

Penalties are associated with this act should any one person not comply and inappropriately disclose medical information. These penalties range from $50,000 to $250,000 and/or imprisonment of up to 10 years. These penalties range from $50,000 to $250,000 and/or imprisonment of up to 10 years. HIPAA regulations supersede any less stringent or contrary state laws.

Compliance Requirements

Corporate Compliance Plan

The Loma Linda University Medical Center (LLUMC) Corporate Compliance Plan is intended to establish a system that promotes prevention, detection and resolution of instances of misconduct that do not conform to federal and state law and federal, state and private payer health care program requirements as well as ethical business policies.

The Plan consists of (1) a "Code of Conduct" which all employees are required to follow; (2) general policies and guidelines for all employees; and (3) specific policies and guidelines for employees performing certain jobs. The Plan also requires employees to report violations of the policies and guidelines in the Plan, which are called "wrongdoings," and outlines how the wrongdoings are to be investigated and punished.

The oversight responsibilities for the Compliance Plan have been assigned to the Compliance Department. Here at LLUMC our Compliance Department is composed of a Chief Compliance Officer, Director of Compliance and other compliance staff. The Compliance Department is responsible for performing routine compliance audits and patient privacy audits as well as audits specifically related to reported violations, implementing compliance and privacy-related polices and procedures, performing compliance and privacy-related employee training and handling other compliance operational activities.

The Code of Conduct

In order to maintain our excellent reputation, including ensuring compliance within our institution, the LLUMC Board of Directors has adopted the following Code of Conduct. All employees are expected to adhere to the terms of this Code.

The following statement of corporate policy constitutes the Code of Conduct of LLUMC. It affirms LLUMC's corporate policy of conducting business and operations in accordance with both the law and the highest standards of Christian ethics.

1. Requires all employees to comply with all appropriate laws and regulations;
2. Requires proper business relationships with government entities and commits to ensuring accuracy on all filings with the government;
3. Commits that we are dedicated to providing medically necessary healthcare to patients without regard to race, creed, color, national origin, gender or disability and that all admissions, transfers and discharges are made in accordance with clinical need and with applicable laws and regulations;
4. Commits that we maintain accurate and reliable corporate records; and
5. States that employees are required to have an undivided loyalty in the exercise of their company responsibilities and that conflicts of interest are to be avoided. (Additional information related to conflicts of interest is described in the section below.)

Compliance Policies

The Compliance Plan has polices and guidelines that are applicable to all staff, several of which are outlined below (For a complete listing of these policies please reference Appendix A of the Compliance Plan).

1. ILLEGAL ACTIONS ON CAMPUS

If you witness any illegal activities, e.g., stealing, physical violence, falsifying information on a patient's bill or medical record, occurring on campus, they must be reported immediately to your supervisor, the Security Department or the Compliance Department.

2. ARRESTS, INDICTMENTS OR CONVICTIONS

Employees who are arrested, indicted or convicted for violating a reportable offense **must** report such arrest, indictment or conviction, even if it is not work-related, in writing to their supervisor within 5 working days. Supervisors shall report this information to the Compliance Department within one business day of receiving the notification from the employee. A determination will be made as to whether the unlawful conduct requires reassignment and/or training.

3. CONFLICTS OF INTEREST

A conflict of interest exists when an employee's personal interests or activities may influence their judgment in the performance of their job duties.

Some examples of a conflict of interest may be:

- ❑ Use of LLUMC, BMC or UHC facilities, equipment and/or space for his or her (or someone else's) own gainful or independent purpose, such as using company computer hardware and software for another job or business in which you participate.

- ❑ Accepting gifts from vendors or customers (including patients and their families):

  Gifts that <u>cannot</u> be accepted are services, loans, discounts, money or valuable articles. Some examples of these gifts would be a gold watch, an interest free loan, **any** cash, check or money order paid to an individual employee. You are required to report *any offer or acceptance* of this type of gift or gratuity to the Compliance Department.

  Gifts that can be accepted include articles of nominal value that vendors give as sales promotions, holiday remembrances, or reasonable entertainment.

Some examples of these nominal gifts would be cookies, candy or other food treats to celebrate the holidays; sales promotional items such as key rings, notebooks, pens, pencils; or reasonable entertainment such as going out to lunch or dinner.

You should review the administrative policies for other types of conflict of interest. If you are unsure if something is considered a "conflict of interest," contact the Compliance Department for guidance.

If you have questions regarding the specific policies that apply to you, please contact the Compliance Department.

Reporting "Wrongdoing"

Although the Compliance Department has oversight responsibility for ensuring that our Compliance Plan is followed and ensuring that we are complying with appropriate regulations, it is important to remember that **compliance is everyone's responsibility**. All employees have an obligation to report any actions they believe are violations of the Corporate Compliance Plan, state or federal laws or the regulations or policies of LLU, LLUMC, LLUBMC and LLUHC. The Institution then has an obligation to investigate and address those concerns.

You can report a compliance concern in two ways.

1. Call the Compliance Department at extension 66455.
2. Call the Employee Compliance Reporting Line at (800) 249-9953. This telephone number is also published in the campus telephone directory.

The Employee Compliance Reporting line is a special compliance reporting number, answered by a contracted vendor, that has been established to report compliance violations which you feel you cannot report to your supervisor. Employees may remain anonymous when reporting violations. Examples of wrongdoing that you would report on this line include:

- Falsifying a bill or a medical record
- Improper possession or use of medications or drugs
- Fraud
- Bribery
- Embezzlement
- Violations of environmental or workplace safety laws
- False statements to the government and/or accrediting agencies (JCAHO)

If you decide to report a concern anonymously, please provide specific details regarding your concerns so that the issue may be appropriately investigated. Additionally, the person taking your call will provide you with a report number as well as a call back date. This serves two purposes:

1. It allows you to remain anonymous and still receive a response regarding your concerns.
2. It allows us to address any additional questions we may have with you via the hotline while still protecting your anonymity.

All reports of wrongdoing will be thoroughly investigated and appropriate corrective action will be taken, if necessary.

Employees will never be punished just for reporting what they reasonably believed to be an act of wrongdoing or a violation of the Compliance Plan or the Code of Conduct. However, an employee may be punished for knowingly making a false report and an employee whose report of misconduct contains admissions of personal wrongdoing will not be guaranteed protection from disciplinary action.

If an employee is found to be in violation of the Compliance Plan, disciplinary procedures, up to and including discharge, may be instituted.

Copies of the Compliance Plan

Medical Center employees can obtain a copy of the Hospital Compliance Plan by calling the Compliance Department at (909) 558-6455 or extension 66455. **Faculty physicians can obtain a copy of their group specific Compliance Plan by contacting their Physician Group Compliance Officer.**

Physician Documentation and Billing Requirements

It is the policy of the Loma Linda Entities that all documentation for clinical services be recorded in accordance with the standards outlined by the Medicare program except where the Medi-Cal program establishes standards that are more stringent in scope.

E&M Services Documentation and Billing Without Regard for Resident Involvement

Billing Requirements

Evaluation and Management services provided by LLU faculty physicians may be billed to patients or third-party payers only under the following circumstances:

1. The service is medically necessary for the care of that patient and/or is screening approved for payment by the patient or by the payer.

2. The service meets the definition, and contains all of the requisite components of an evaluation and management (E&M) service as described in the current edition of CPT and the CMS (FORMERLY HCFA)/AMA Documentation Guidelines

Only services actually provided may be billed (no-shows may not be billed). See operating policy or contact the Compliance Department for conditions required for billing patient no-shows.

Documentation Requirements

1. Every physician who provides or supervises the provision of services to a patient shall be responsible for the correct documentation of the services that were rendered.

2. Except as set forth in the documentation guidelines with respect to patient histories, e.g., ROS and PFSH, the required documentation must be entered in the record or dictated personally by the physician.

3. Documentation entered personally by the physician must be legible. Illegible entries will be considered to constitute missing documentation.

4. Such documentation shall include documentation of all of the elements of each service provided. Each physician shall be responsible for acquiring a working knowledge of the key components and the elements comprising those key components of the E/M services that he or she routinely provides or supervises. For the purpose of this obligation, those elements are the elements of the patient history, the physical exam and the medical decision-making that determine the CPT code to be assigned to the physician service.

5. Each physician shall be responsible for assuring that the medical record for every patient for whom the physician provides, or supervises the provision of, E&M services includes appropriate documentation of the applicable key components of the E&M service provided or supervised by the physician. For purposes of this provision, key components are the patient history, physical examination and medical decision making. Components such as time, counseling, and coordination of care need only be included where they contribute to or determine the CPT code assigned to the service or are important to the subsequent treatment of the patient.

E&M Services Documentation and Billing With Resident Involvement - Medicare and Private Payers

Billing Requirements

A. In addition to assuring that all of the components for the E/M services furnished during an encounter have been performed and recorded in the patient record, the teaching physician is responsible for (1) being physically present during the resident's performance of all of the key components of the E/M service billed personally, or (2) repeating the key elements of the key components of the service provided by the resident in order to submit claims to third-party payers for reimbursement of professional services.

1. With the exception of psychiatric services, "present" means being physically present in the same room and observing the resident's activity. For psychiatric visits involving residents, the presence requirement may be met by using one-way mirrors or glass or by live video.

2. If the teaching physician was not present when the resident performed the history and physical, in order to bill for the services rendered, the teaching physician must:

    - confirm the history with the patient; and

    - re-perform key elements of the physical.

3. **If the teaching physician neither re-performed key elements of the resident's services nor was present when they were performed, no bill is to be submitted for services by the teaching physician and no charge capture form is to be completed for the resident's services.**

4. For time-based services, such as critical care, it is only the teaching physician's time that is counted and documented. None of the resident's time may be counted for billing purposes.

Documentation Requirements

A. In all cases, the medical record shall accurately reflect the actual involvement of the teaching physician in the care and treatment of the patient.

B. For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the service when performed by the resident, **and**
- The participation of the teaching physician in the management of the patient.

C. Documentation by the resident of the presence and participation of the teaching physician is **not** sufficient to establish the presence and participation of the teaching physician. The combined entries of the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

D. Common Scenarios for Teaching Physicians Providing E/M Services

Scenario 1. The <u>teaching physician personally performs all the required elements</u> of an E/M service without a resident. In this scenario, the resident may or may not have performed the E/M service independently.

In the absence of a note by a resident, the teaching physician must document as he or she would document an E/M service in a non-teaching setting.

Where a resident has written notes, the teaching physician's note may reference the resident's note as outlined in the minimally acceptable documentation examples below.

Minimally acceptable documentation examples for Scenario 1:
Admitting note: "I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care."
Follow-up visit: "Hospital Day #3. I saw and evaluated the patient. I agree with the findings and plan of care as documented in the resident's note."
Follow-up visit: "Hospital Day #5. I saw and examined the patient. I agree with the resident's note except the heart murmur is louder, so I will obtain an echo to evaluate."

Scenario 2. The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service.

In this case, the teaching physician must document that he or she was present during the performance of the critical or key portion(s) of the service and that he or she was directly involved in the management of the patient.

The teaching physician's note should reference the resident's note.

Minimally Acceptable Documentation Examples for Scenario 2:
Initial or follow-up visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."
Follow-up visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Scenario 3: The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) with or without the resident present and, as appropriate, discusses the case with the resident.

In this instance, the teaching physician must document that he or she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient.

The teaching physician's note should reference the resident's note.

Minimally Acceptable Documentation Examples for Scenario 3:
Initial visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDS."
Initial or follow-up visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."
Follow-up visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's findings and plans as written."
Follow-up visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker now 3/5; MRI of L/S spine today."

The above examples of minimally acceptable documentation could be used in both the impatient and outpatient setting.

It is important to note that the documentation examples above are considered by CMS to be the minimum amount of documentation necessary for the teaching physician to bill for an E/M service. Although arguably, the documentation examples above do not say much more than the UNACCEPTABLE DOCUMENTATION examples below, the CMS Program Memorandum clearly indicates that the types of documentation listed below will be considered unacceptable.

E. Examples of UNACCEPTABLE DOCUMENTATION by the teaching physician to tie to the resident's note.

- "Seen, examined, agree"
- "discussed with resident, agree"
- "agree with resident's note"
- "patient seen and evaluated"

The above types of phrases should never be used as the teaching physician's sole documentation for E/M services.

F. If a note is dictated, written, or electronically recorded by anyone other than the Teaching physician, the note must specify the name of the person who did the documentation.

G. When the teaching physician personally performs an E/M service in any department that has or receives residents, he or she shall use descriptions including the personal pronoun "I" (e.g., "I obtained," "I examined") when describing the service in a note for the patient record.

E&M Services Documentation and Billing With Resident Involvement - Medi-Cal

Billing Requirements

Under Medi-Cal, supervision by the teaching physician of a resident performing services is not sufficient to support billing the MediCal program. The teaching physician must also render medically necessary direct patient care services. The teaching physician must actually participate with the resident in delivering (or repeat) the services to be billed.

Documentation Requirements

A. In addition to assuring that all of the components for the E/M services furnished during an encounter have been performed and recorded in the patient record, the teaching physician is responsible for personally recording the fact that he or she **provided** or **repeated** key elements of the key components of the service provided by the resident.

B. The documentation supporting the teaching physicians participation in services to MediCal patients involving residents must be written or dictated personally and signed by the teaching physician and must include a description of the history, physical exam and decision making that substantiates the level of service provided in accordance with the current CPT guidelines, as well as describing the teaching physician's participation.

C. Documentation of the teaching physician services provided and billed to the Medi-Cal program shall include:

1. Progress/operative notes personally written or dictated and signed by the teaching physician.

2. Progress notes that are separate and distinct from those of a supervised house staff member, but which may include references to findings by a house staff member when:

    a) The service referenced was also provided by the teaching physician;
    b) It is clear which note and specific item in the note is being referenced;
    c) The referenced item substantiates the level of service billed by the teaching physician; and
    d) The referenced house staff findings do not constitute the only form of documentation/substantiation of the medical care provided by the teaching physician.

3. Progress notes which detail/document necessary medical treatment performed directly for the patient by the teaching physician.

4. Progress notes which substantiate the service/level of service provided by the physician, in accordance with the current CPT-4 and the Medi-Cal Medical Services Provider Manual.

Surgical and Other Procedural Services Documentation and Billing - Medicare and Private Payer patients

Billing Requirements

A. No teaching physician shall bill, or cause to be billed, any procedure performed by a resident unless the physician was personally present in the same room with the resident and supervising the resident's performance of the key portions of the procedure. The teaching surgeon is responsible for determining the key portions of the procedure.

    1. For surgery, opening and closing are not key portions of the procedure. The teaching surgeon need not be physically present during opening and closing, but rather needs only to be immediately available in the OR suite, such as within shouting distance of the OR.

B. A teaching physician may not supervise more than two concurrent surgeries. If more than two concurrent surgeries are supervised, neither one of them is billable.

    1. Surgeries may not be scheduled in such a way that the key portions will overlap. If the key portions overlap, the teaching physician may not bill for either procedure.

    2. When supervising two concurrent surgeries, the key or intraoperative portions may not overlap. All key portions of one procedure must be completed prior to beginning the second procedure.

    3. If a teaching physician undertakes to perform another procedure during such time as he or she is "immediately available" for the non-key portions of surgery he or she shall arrange for another surgeon who is not covering or immediately available for any other surgery to cover that non-key portion of surgery.

C. The teaching surgeon shall determine which postoperative visits are key visits for the global surgical service and shall be present and document his or her presence during, or performance of, the key components of those postoperative visits. If a global service is to be billed, it is not acceptable for the teaching surgeon to determine that no postoperative visits are key visits. This policy includes all procedures that have global service billing requirements, regardless of the length of the global service period.

D. For anesthesia, the preoperative and postoperative visits are not key portions of the procedure. The key portions are the induction, emergence, and any other critical portion of the procedure. The anesthesiologist must personally document his or her presence during the performance of the key components of the service.

E. For minor procedures (procedures that typically take only a few minutes to complete and involve relatively little decision making) the **entire** procedure is the key portion and the teaching physician must be physically present for the entire procedure in order to bill. The teaching physician must personally document his or her presence during the procedure.

F. For endoscopies and other invasive diagnostic viewing the key portion includes the insertion of the viewing device, the entire viewing and removal of the device. Presence for this purpose means in the suite or room and not viewing by monitor in another suite or room. The teaching physician's documentation must include a brief statement summarizing what he or she saw during the viewing and agreeing with or revising, the resident' s note.

Documentation Requirements

A. Whenever a physician personally performs a procedure, or examines and interprets a diagnostic medium or test, in a department that has or receives residents, he or she shall describe whatever service was performed using the personal pronoun “I” (“I performed” or “I examined the specimen and found”) when documenting the service.

B. Whenever a physician involves a resident in the performance of a procedure, the supervising physician is responsible for personally documenting the fact of his or her presence during, and supervision of, the resident's activity during such key components in the patient's record. If the resident enters the note describing the procedure, the supervising physician should also make an entry in the patient record confirming or revising the resident's note. Special rules applying to the documentation of teaching physician presence for procedures involving residents are:

    1. If the teaching physician was present during the entire procedure, his/her note should state the same and should document that he/she has reviewed the resident’s note and agrees with or revises the note.

    2. If the teaching physician was not present during the entire procedure, his/her note should list the key portions of the procedure for which he/she was present, document his/her immediate availability during the non key portions or who was immediately available, and document he/she has reviewed the resident’s note and agrees with or revises the note.

C. When supervising two concurrent surgeries, the key or intraoperative portions may not overlap. The teaching physician is responsible for documenting his or her

presence during the intraoperative portions of both surgeries and the fact that those portions did not overlap.

Use of the GC modifier

When a procedure or service for a Medicare patient has been performed in part by a resident/fellow and is billed by the teaching physician, the -GC modifier should be appended to the CPT code.

Documentation Requirements for Ordering Outpatient Laboratory and Other Diagnostic Tests

A. When ordering tests, for which Medicare reimbursement will be sought, the physician should only order tests that are medically necessary for the diagnosis or treatment of the patient.

    1. Generally, tests ordered for screening or preventive care purposes are not covered services unless specifically covered by Medicare regulations (e.g., mammograms).

    2. Tests are considered to be screening tests when a patient displays no symptomatology or evidence of disease.

    3. If screening tests are ordered, they should be specifically stated as such so that these tests are not submitted to the Medicare Program for reimbursement.

B. A diagnosis or reason for the test (sign, symptom, complaint or appropriate ICD-9 diagnosis code) must be documented on the test requisition or other order submitted by the ordering physician.

C. When more than one separately billable test is ordered on a requisition, there should be a correlation of the applicable diagnosis for each of the ordered tests.

Billing for Services Involving Nonphysician Professionals

Generally, if the Medical Center employs a nurse practitioner and the physician's group does not follow specific leasing arrangements to pay for those services, none of the services provided by that nurse may be billed as "incident to" the physician's services. If you have questions regarding this area, please consult with the Compliance Office for further direction.

Billing for Physician or Institutional Services Involving Investigational Drugs, Devices, Procedures or Therapies

There are many complex rules associated with billing in the area of investigational drugs, devices, procedures and therapies. Generally speaking, drugs and devices not having

received approval for marketing or an investigational exemption may not be billed to any governmental payer. Category A devices (and associated services if the purpose of the service is to implant or use the device) may not be billed to Medicare and may only be billed to other governmental programs if prior written approval is obtained and documented.

Patient Liability and Payment for Non-Covered Services

A. Non-covered services may not be billed to the Medicare program. Non-covered services include those that are not medically necessary (see "Definition of Medical Necessity" page 12 of this document) are custodial care, screening, or are personal comfort items.

B. Non-covered services may be billed to the patient if all of the following criteria are met prior to rendering the service. In such instances, a no pay bill shall be filed with Medicare.

    1. the patient is furnished written disclosure of the anticipated noncovered service and the estimated charges associated with the noncovered service.

    2. the patient signs the above document and agrees, in writing, to be personally responsible for payment.

Waiver of Co-Insurance and Deductibles

A. Patients in federal or state health plans:

Part or all of any deductible or coinsurance may be waived if the following requirements are met and documented in the patient's financial record:

1. the waiver has not been advertised
2. waivers are not routinely offered
3. a determination has been made that the patient has a financial need for the waiver or reasonable efforts to collect the payment have been unsuccessful

B. Patients with private health care coverage:

Waiver of deductibles or coinsurance is discretionary only if the insurance or managed care plan involved does not affirmatively require collection or an attempt at collection. If waiver of coinsurance or deductible is granted, the financial record must reflect a determination that their insurance or coverage program does not impose an obligation to attempt collection.

C. Patients who are admitting physicians or immediate family members of admitting physicians:

No waiver of coinsurance or deductible may be offered or given by LLUMC regardless of insurance or health plan type.

Other Important Information

When to Bill a Consultation vs. a Visit
Taken from the CMS (formerly HCFA) Program Manual – Medicare Carriers 15506 CONSULTATIONS (Codes 99241 - 99275)

A. Consultation Versus Visit. –Medicare will pay for a consultation when all of the criteria for the use of a consultation code are met:

(1) Specifically, a consultation is distinguished from a visit because it is provided by a physician whose **opinion or advice** regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).

(2) A **request for a consultation** from an appropriate source and **the need for consultation** must be documented in the patient's medical record.

(3) After the consultation is provided, **the consultant prepares a written report of his/her findings** which is provided to the referring physician.

B. Consultation Followed By Treatment - Medicare payment may be made regardless of treatment initiation unless a transfer of care occurs. A transfer of care occurs when the referring physician transfers the responsibility for the patient's complete care to the receiving physician at the time of referral, and the receiving physician documents approval of care in advance. The receiving physician would report a new or established patient visit depending on the situation (a new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years) and setting, e.g., office or inpatient.

A physician consultant may initiate diagnostic and/or therapeutic services at an initial or subsequent visit. Subsequent visits (not performed to complete the initial consultation) to manage a portion or all of the patient's condition should be reported as established patient office visit or subsequent hospital care, depending on the setting.

C. Consultations Requested by Members of Same Group — Medicare will pay for a consultation if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met. (See §15506A.)

D. Documentation For Consultations -- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician.

In an emergency department or an inpatient or outpatient setting in which the medical record is shared between the referring physician and the consultant, the request may be documented as part of a plan written in the requesting physician's progress note, an order in the medical record, or a specific written request for the consultation. In these settings, the report may consist of an appropriate entry in the common medical record. In an office setting, the documentation requirement may be met by a specific written request for the consultation from the requesting physician or if the consultant's records show a specific reference to the request. In this setting, the consultation report is a separate document communicated to the requesting physician.

E. Consultation for Preoperative Clearance - Pay for the appropriate consultation code for a preoperative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

F. Postoperative Care By Physician Who Did Preoperative Clearance Consultation - Advise physicians that if, subsequent to the completion of a preoperative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patient's condition(s) during the postoperative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the postoperative period.

A physician (primary care or specialist) who performs a postoperative evaluation of a new or established patient at the request of the surgeon may bill the appropriate consultation code for evaluation and management services furnished during the postoperative period following surgery as long as all of the criteria for the use of the consultation codes are met and that same physician has not already performed a preoperative consultation.

G. Surgeon's Request That Another Physician Participate In Postoperative Care - If the surgeon asks a physician who had not seen the patient for a preoperative consultation to take responsibility for the management of an aspect of the patient's condition during the postoperative period, the physician may not bill a consultation because the surgeon is not asking the physician's opinion or advice for the surgeon's use in treating the patient. The physician's services would constitute concurrent care and should be billed using the appropriate level visit codes. See §15506F if the physician did a preoperative clearance consultation.

Definition of Homebound
Taken from the CMS (formerly HCFA) Program Manual – Medicare Carriers 2051.1

An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their home would require a

considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block, or a drive would not necessitate a finding that the individual is not homebound so long as they are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. The following are some examples of homebound patients:

1. A beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk;

2. A beneficiary who is blind or senile and, therefore, requires the assistance of another person in leaving his place of residence;

3. A beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and therefore, requires the assistance of another individual in leaving his place of residence;

4. A beneficiary who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, or walking stairs only once a day;

5. A beneficiary with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity; and

6. A beneficiary with a psychiatric problem if his illness is manifested in part by a refusal to leave his home environment or it would not be considered safe for him to leave his home unattended, even if he has no physical limitations.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of this reimbursement unless his condition is analogous to those above.

Definition of Medical Necessity
Taken from the Medicare Part B Basic Billing Guide, produced by National Heritage Insurance Company (NHIC), our Medicare Carrier

Medicare will only cover items and services, which are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.

To be considered medically necessary, items and services must have been established as safe and effective. The items and services must be:

- Consistent with patient symptoms or diagnosis of the illness or injury under treatment;
- Necessary and consistent with generally accepted professional medical standards (in other words, not still experimental or investigational);
- Not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier;
- Furnished at the most appropriate level which can be provided safely and effectively to the patient primarily for the convenience of the patient and others .

This means that there are some services for which Medicare does not pay because the services are non-covered, the services are not considered to be effective and accepted by the medical profession, and/or the services are not appropriate for the situation or diagnosis.

In most cases, as a physician, you may collect charges from patients for services that are completely denied as not covered by Medicare, i.e., general program exclusions. Some examples of non-covered services are:

- routine physicals
- routine health screenings, such as serum cholesterol screening, hearing tests, diabetes screening, thyroid function screening, etc.
- most self-administered prescription drugs (except for pneumococcal, influenza, hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infections)

An exception applies when the item or service is found to be "not medically reasonable and necessary" and the patient was not given advance notice of the likelihood of Medicare's denial, i.e., Advance Beneficiary Notice. If payment is denied on the grounds that the service was unnecessary, the Medicare patient's liability is limited and he or she is protected from having to pay for the service because he or she could not have been expected to know at the time that Medicare would not pay.

Whenever you provide a Medicare patient with services that you know or believe Medicare will determine to be medically unnecessary, and thus will not pay for, you are required to notify the patient **in writing before performing the service, the reasons you expect Medicare's denial.** If such written notice is not given, and your patient did not know that Medicare would not pay, your patient cannot be held liable to pay. Keep in mind that Medicare will not pay for these charges either.

The requirement to advise the patient applies both to services that you render and services which you order or refer, such as laboratory tests and other diagnostic tests done at a remote site.

For a copy of a sample Advance Beneficiary Notice (ABN), including examples of acceptable statements of reasons that Medicare is likely to deny payment, please contact the Compliance Office.

Maternity Care Reminders:

Pain Management Services:
California Health and Safety Code 1256.2 states that there cannot be differing standards of obstetrical care based upon a patient's source of payment or ability to pay for medical services. The law states that it shall constitute unprofessional conduct within the meaning of the Medical Practice Act, Chapter 5, for a physician or surgeon to deny, or threaten to withhold pain management services from a woman in active labor based upon that patient's source of payment, or ability to pay for medical services.

Requirements for minimum hospital stay following birth:
Following a normal vaginal delivery, the mother and her newborn child are entitled to a hospital stay of no less than 48 hours. Following a cesarean section, the mother and her newborn child are entitled to a hospital stay of no less than 96 hours.

For information regarding exceptions to the time frames for discharge, please consult with the Compliance Office for further direction.

Questions:

Questions related to compliance issues or additional information about the Compliance Plan may be obtained by calling the Compliance Office at (909) 558-6455 or extension 66455.

MEDICAL RECORD DOCUMENTATION ISSUES

• Electronic Patient Folder

The Medical Center is committed to improving the flow of patient information through the establishment of an "Electronic Patient Folder" (EPF) which stores and retrieves patient documentation using computers, instead of paper. In most cases, reports generated by other computer systems are being interfaced directly to EPF. Handwritten documentation is being scanned and saved as an image.

All dictated, transcribed reports are interfaced directly to EPF and physicians are authenticating them using the computer. All chart completion after discharge is handled via computer. In order to do this, each physician will need an EPF login with password, and a PIN number to authenticate documents.

Options for obtaining more information on EPF include:

- Printed Self-Study Materials
- Hands-on Classes
- Individual Coaching Opportunities

Hands-on classes are currently arranged by request only and are designed for groups of 3 to 9 people. Individualized coaching is available in the Health Information Management Department on the 5th floor of the Medical Center.

• Order Writing

Diagnostic Tests: Please remember to provide a reason for all diagnostic tests you order. This includes all requests for such tests as chest x-rays, electrocardiograms, cytology. This allows the test interpreter to ensure the report answers your specific question. Third party payers require a test to have a reason before they will reimburse for it. This technically has to be an ICD-9 codeable reason. Clinical laboratory tests, e.g., complete blood count, protime, also require a reason and this must be written especially in the ambulatory settings like the Pediatric Teaching Office, Primary Care Clinic, Family Medicine Clinic, Urgent Care, and Emergency Department.

Reasons can be <u>either</u> a diagnosis, e.g., CHF <u>or</u> a symptom, e.g., shortness of breath. However, "rule out" cannot be used as a reason. For example, "rule out CHF" should be stated as "dyspnea," if that is the relevant symptom.

The unit secretaries will not take off orders for diagnostic testing that are not accompanied by an appropriate reason. They have been instructed to page the order writer to have the order rewritten. The invalid order will be circled and flagged for your convenience, so it can be

rewritten with an appropriate reason. Please do not write in the reason on the original order because such an order can be "buried" beneath subsequent orders and might be missed. Unit secretaries cannot accept verbal orders.

Please thank any unit secretary who reminds you of this requirement. This is NOT their idea! By calling your attention to any orders without reasons, they ensure the patient receives prompt testing. There are signs on the unit to remind you of this policy.

This requirement for reasons applies to private practice, HMO, and academic settings. We hope the habits you develop will help your practice when you complete your residency program.

Dating, Timing, Signing: It is a requirement of the medical staff that all clinical entries be accurately dated, timed, and signed. An electronic signature is the equivalent of a regular signature and passwords that allow for electronic signatures are not to be used by anyone other than the person issued the password. When a resident writes orders, the resident's signature consists of his/her legible written signature and beeper number followed by the attending physician under whose direction the order is being written. For example:

Give Tylenol #3 1 tab every 4 hours as needed for severe headache.
John Doe, MD / Daniel Giang, MD
#9367

This allows the medical staff to attribute for medical care activities to the appropriate attending physician for reappointment and privileging data.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

This federal legislation is important to you because you are seeing and treating patients within the hospital facilities operated by Loma Linda University Medical Center (LLUMC). EMTALA first became law in 1986, and is known colloquially as "the COBRA law."

First, this legislation represents a federal mandate for every patient who comes to an emergency department to be examined and certified as not having an emergency medical condition. Obviously, this process may be quite simple, but it also might require consultations from multiple services as well as extensive diagnostic testing. Failure on the part of the hospital to fulfill this requirement may result in the hospital's removal from the Medicare program, a loss that would shut most hospitals down. Failure on the part of a consultant to take part in a necessary evaluation to determine that no emergency medical condition exists may result in a $50,000 fine per episode to the individual physician.

Next, transfers out of the hospital to other care facilities, both from inpatient sites and the emergency department, must meet strict criteria. These criteria include physician certification that the patient is stable, proper arrangements prior to transfer, and patient consent for the transfer. Failure to fulfill these obligations brings the same fines as noted above.

Finally, because LLUMC is a tertiary care facility, we cannot turn away legitimate requests for a higher level of care from other facilities, which are unable to provide the care. Our decisions about these requests for transfer must be based on medical necessity alone and may not take into consideration the patients' ability to pay. Again, the same fines mentioned above can be levied if we fail to meet the law on this issue.

It is imperative, for your own benefit and the benefit of LLUMC, that these laws are strictly adhered to. They have been put in place to maintain safety of patients, but the details required in documenting adherence to the law can be formidable. You must take your on-call responsibilities seriously, as failing to respond when on-call will increase your exposure under this law. You must take great care when transferring patients to another facility as the transfer creates legal exposure by definition. You must never turn away a legitimate request for a higher level of care for a patient at another facility.

Thank you for working together as a medical team in taking good care of our patients. If you have questions after hours about EMTALA, it is suggested you contact an attending in the Emergency Department. Physicians in Emergency Medicine have been profoundly impacted by EMTALA and are willing to answer questions about the law 24 hours a day.

Fraud and Abuse

Introduction

It is estimated that 10% (12 to 23 billion dollars per year) of Medicare costs are wrongly spent on fraud and abuse incidents. According to the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, providers commit 80% of the existing cases of Medicare abuse and 90% of the Medicare fraud cases. In order to reduce these losses, CMS has committed to combating fraud and abuse by implementing mechanisms for prevention, early detection and correction.

The Office of Inspector General (OIG) is primarily responsible for Medicare fraud investigations and provides support to the U.S. Attorney's Office for cases that lead to prosecution. In addition, the OIG coordinates their efforts with other entities such as the FBI, IRS, Medicaid, and other state agencies. Additionally, Medicare works through the local Medicare contractors to provide ongoing education to both providers and beneficiaries.

This training is designed to provide education to all of our employees regarding the different situations that they may encounter concerning potential fraud and abuse within the Medicare program.

The objectives of this material are to:

- ◊ Define Medicare fraud and abuse (including examples).
- ◊ Educate employees on the potential consequences of fraud and abuse.
- ◊ Teach safeguard measures to help protect against fraud, waste, and abuse.
- ◊ Discuss Medicare legislative issues.
- ◊ Discuss how we can appropriately monitor ourselves to assist in the prevention of potential fraudulent or abusive behaviors.

Fraud

Fraud is defined as the intentional deception or misrepresentation which an individual or entity makes, knowing it to be false and that the deception could result in some unauthorized benefit.

Examples of fraudulent activities could include:

1. Billing for services not rendered. Keep in mind that according to Medicare rules, if a service wasn't documented, it wasn't done. Therefore if you provide care to a patient and do not fully document what services were provided, you could potentially be submitting a fraudulent claim.
2. Signing blank records or certification forms. If you were to sign a blank record or certification form, that form could be used by another party to obtain Medicare payment for services not rendered or not medically necessary.
3. Misrepresenting as medically necessary, non-covered services by using inappropriate procedure or diagnosis code.

4. **Consistently** using procedure/revenue codes that describe more extensive services than those actually performed - **upcoding**. For example, routinely/consistently (a) billing a higher level E&M service than what is supported by the documentation in the medical record, (b) billing an established patient as a new patient visit, (c) billing a follow-up visit as a consult (d) billing for a 2-view chest x-ray when only a single view was performed.
5. Soliciting, offering, or receiving a kickback, bribe, or rebate. This could happen if a physician were to receive payment (either monetary or some item of value) in return for referring a patient to a particular clinic or service.
6. Using an incorrect or inappropriate provider number in order to be paid. For example, a provider bills for services as if they were his own when the services were provided by another entity.
7. Selling or sharing patients Medicare numbers so false claims can be filed.
8. Offering incentives to Medicare patients that are not offered to non-medicare patients (e.g., routinely waiving or discounting deductible or co-insurance amounts).
9. Falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government.

It should be noted that if a provider fails to correct mistakes and/or return any known overpayments, he/she may be suspected of fraud.

Abuse

Abuse is defined as the receipt of payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Examples of abusive activities could include:

1. Collecting in excess of the deductible or co-insurance amounts due from a patient.
2. **Routinely** submitting duplicate claims. This could be considered abuse even if it doesn't result in duplicate payment.
3. Billing for services grossly in excess of those needed by patients (e.g. billing a complete lab profile when a single diagnostic test is all that is necessary to establish diagnosis).
4. Inappropriate or incorrect information filed on cost report.
5. Using procedure or revenue codes that describe more extensive services than those actually performed - **upcoding**. Examples of upcoding could include: (a) billing a higher level E&M service than what is supported by the documentation in the medical record, (b) billing an established patient as a new patient visit, (c) billing a follow-up visit as a consult.
6. Requiring a deposit or other payment from a patient as a condition for admission, continued care, or other provision of services.

7. Unbundling or "exploding" charges (e.g., reporting a series of codes when there is one specific code which describes and includes payment for all components of the series of codes).

Potential Consequences of Fraud and Abuse

Criminal/Civil Penalties

Defrauding the U.S. Government or any of its programs is a federal crime and doing so may result in an individual being sent to prison, fined or both. It is important to remember that a provider is ultimately responsible for the actions of his/her staff. This means that should a member of the provider's staff inappropriately submit a claim to Medicare or Medi-Cal, the provider would be subject to the same penalties as if he/she committed the inappropriate act. Criminal convictions usually include restitution, significant fines, and depending on the state, loss of licensure.

Additionally, the U.S. Attorney may also choose to file a civil lawsuit or settle the case. In these instances, the provider pays money to the government in the form of penalties and fines. The penalty received may include the provider excluded from the Medicare and Medi-Cal programs for a specified time period.

When it has been determined that Medicare laws have been violated, the **Medicare and Medicaid Patient and Program Protection Act of 1987** authorizes the imposition of civil monetary penalties. The following examples would result in penalties: (1) violation of the Medicare assignment provisions; (2) hospital unbundling of outpatient surgery costs; (3) patient "dumping" based on their inability to pay. Penalties for such acts may reach $50,000 per violation, and result in exclusion from the Medicare program for a minimum of 5 years.

Actions resulting from Kickbacks, Bribes, False Statements, or Rebates

Actions resulting from Kickbacks, Bribes, False Statements, or Rebates are considered a felony, and if convicted, the penalties can include fines that shall not exceed $50,000 per violation, or imprisonment that shall not exceed 5 years per violation, or both.

Exclusion Authority

If a provider has been convicted of a healthcare related offense, the OIG has the authority to exclude them from the Medicare/Medi-Cal programs. There are two types of exclusions that exist:

1. Mandatory – Results when a conviction of fraud has occurred.
   Examples – Crime related to the Medicare or Medi-Cal programs, or abuse/neglect of a patient.
   A mandatory exclusion has a 5-year minimum.

2. Permissive – Can be issued in cases that do not result in a fraud conviction, provided certain conditions and requirements have been met.
   Examples – Theft, embezzlement, obstruction of justice, submission of excessive claims, furnishing unnecessary services, or default on health education loans, or the unlawful manufacture, distribution, or dispensing of a controlled substance.

Individuals or entities excluded from the Medicare program are identified on a sanctioned provider list developed by the OIG. This list should be checked before adding a provider to a physician group or medical staff, purchasing or considering involvement in a medical facility or other entity that may seek payment from Medicare. The OIG exclusions list is accessible on the internet at: http://exclusions.oig.hhs.gov/cgi-bin/oig_counter.pl. Currently, LLUMC has a process in place to check all employees, vendors and contractors against the OIG exclusion list.

Contractor and CMS Actions

In addition to the actions taken by the federal government, Medicare contractors (e.g., Blue Cross, NHIC, Mutual of Omaha) and CMS have a responsibility to ensure that all claims paid are appropriate**.** Medicare contractors (with authorization from CMS) may impose the following sanctions on those individuals who abuse the Medicare program:

Action	Initiated By
Provider education and warning	Contractor
Revocation of Assignment privileges	CMS
Withholding of Provider's Medicare payments and recovery of Medicare's overpayments	Contractor with instruction from CMS
Exclusion of Provider from the Medicare program. Posting of the Provider's name on national Sanctioned Provider list that is sponsored by the U.S. government	OIG

Safeguards

Do You	Then
Use a billing service or consultant?	➢ You are still ultimately responsible for the accuracy and validity of your claims ➢ You must still stay current with governmental regulations (Once a regulation has been published, you are responsible for its content regardless of whether or not you have read the publication.) ➢ You should conduct periodic audits to determine the job being done by the department or billing service
Provide services to Medicare beneficiaries?	➢ You must be aware of the services covered by Medicare ➢ You must recognize what services are medically necessary and reasonable for the patient's condition ➢ Follow Medicare guidelines and

	procedures when documenting or reporting services ➢ Verify the identity of the person presenting for treatment

It is the provider of service who is ultimately responsible for the verification of the identity of each patient receiving services from them. If services are rendered to a beneficiary impersonator, providers may be liable for an overpayment. Medicare receives thousands of calls and letters from beneficiaries reporting lost or stolen Medicare cards. Beneficiary impersonators are becoming more common as the cost of health care rises. Because of this, it is wise for providers to implement measures that will decrease the likelihood of providing care to a non-beneficiary, e.g., request picture ID

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Approximately 6% of all claims filed to Medicare are denied as duplicate claims. Medicare's expectation is that this rate should be less than 1%. Since Medicare views duplicate claim submission as abuse, it is in the provider's best interest to implement systems that eliminate this.

Medicare regulations are such that most hospitals are paid a pre-determined amount for care of an inpatient. This pre-determined amount is referred to as a DRG (Diagnosis Related Group) and is based on the diagnosis that the patient was treated for while in the hospital. With a few exceptions, it doesn't matter if a patient was in the hospital for 1 day or 10 days, payment for treating the patient would be the same, based on the particular DRG. Since there are occasions where a patient is admitted, stabilized, and transferred to another hospital, a payment methodology was developed for these situations. Rather than be paid an entire DRG amount, the transferring hospital is paid a per diem (daily) amount, not to exceed the full DRG amount. The discharging hospital, however, receives full DRG payment. Given the potentially large difference in payment amount between a "transferred" patient and a "discharged" patient, the OIG has taken an interest in this issue. Therefore, it is important for providers to develop policies and procedures that detail the process for determining the proper discharge status code.

Non-covered services are those which are **not** recognized as payable by Medicare. As such, the patient is responsible for payment. Some examples are: routine physicals or screenings, outpatient oral medications, self-administered drugs, cosmetic surgery.

Under section 1862(a)(l) of the Medicare Law, Medicare will only pay for services that it determines to be "reasonable and necessary." In the event that Medicare determines a service(s) to be **not** "reasonable and necessary," it is permissible for the patient to be charged, provided they have received/signed an Advanced Beneficiary Notice (ABN) from the provider **PRIOR** to the service being provided.

Legislative Items

The False Claims Act prohibits knowingly filing a false or fraudulent claim for payment to the government, knowingly using a false record or statement to obtain payment on a false or

fraudulent claim paid by the government, or conspiring to defraud the government by getting a false or fraudulent claim allowed or paid.

The Anti-Kickback Statute prohibits soliciting, receiving, offering, or paying for goods or services which may be payable, in whole or in part, by Medicare or Medi-Cal.

The Safe Harbors Provision protects certain groups from criminal prosecution and/or civil sanctions for actions which may appear as unlawful or inappropriate according to Medicare law.

The Health Insurance Portability and Accountability Act (HIPAA), also referred to as the Kennedy-Kassebaum bill, was signed into law in August of 1996. There are a number of provisions to this Act, several of which are of interest to the healthcare community:

- ◊ Administrative Simplification requires all healthcare providers and health plans that engage in electronic transactions to use a single set of national standards and identifiers. Electronic health information systems must meet security standards. This should result in more cost-effective electronic claims processing and coordination of benefits.
- ◊ Protection of health insurance coverage for workers and their families when they change or lose their jobs. This includes an estimated 25 million Americans.
- ◊ Significant changes to anti-fraud and abuse activities. These changes will occur through the following mechanisms – Medicare Integrity Program (provides review and audit activities); creation of programs encouraging beneficiaries to report fraud and abuse; issuance of advisory opinions; establishment of a national data bank to record information about those who have committed fraud or abuse.

The Balanced Budget Act (BBA) of 1997 is a far-reaching law that when coupled with HIPAA provides additional legal weapons against fraud, abuse and waste in federal healthcare programs. In particular, the Act includes the following:

- ◊ Exclusion from the Medicare/Medicaid programs for at least 10 years (potentially permanent exclusion, depending on circumstances) for conviction of a health care related crime.
- ◊ Authority to refuse to enter in agreements, or terminate an agreement, with providers who have been convicted of a felony under federal or state law.
- ◊ Enforcement of civil monetary penalties of up to $10,000 for contracting with, or attempting to contract with, an individual or entity that has been excluded from a federal healthcare program.
- ◊ Penalties of up to $50,000 plus up to 3 times the amount of remuneration offered, paid, solicited or received, for each violation of the anti-kickback provisions.
- ◊ Beneficiaries right to itemized statements. Failure to supply the statement within 30 days of the request may result in a fine of $100 for each unfilled request.
- ◊ Creation of a new health insurance program designed to provide health benefits coverage to certain uninsured, low-income children who are not eligible for the Medicaid program.
- ◊ Penalties of up to $25,000 for health plans that fail to report adverse actions as required under HIPAA's healthcare fraud and abuse data program.

Physician Self Referral Laws (commonly referred to as the Stark Law) prohibit a physician from referring a Medicare or Medi-Cal patient to an entity for the provision of certain "designated" health services if the physician or a family member has a financial relationship with that entity. Examples of "designated" health services are: lab, physical therapy, occupational therapy, Durable Medicare Equipment (DME), home health services, prosthetics/orthotics. There are exceptions to the Stark Law that exist; however, given their limitations and conditions, it is advisable to seek legal counsel for clarification.

More detailed information regarding the topics discussed in this training can be found in the Medicare booklet titled "Medicare Fraud & Abuse: A Practical Guide of Proactive Measures to Avoid Becoming a Victim." To review a copy of this booklet and/or a video presentation, please contact the Compliance Department at x-66455.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was originally Intended to accomplish two main purposes: 1) making one's insurance "portable," meaning that if you changed employers and were previously covered under a group policy with your prior employer, your new employer would have to waive any pre-existing requirements within their plan; and 2) holding providers more "accountable" by increasing the federal government's fraud enforcement authority.

Because this was popular legislation, it was added to and amended as it moved through Congress. One of the items that was added was the Administrative Simplification Section. This is arguably the most significant part of the legislation and the portion of the legislation that will most impact us here at Loma Linda University Medical Center (LLUMC).

Although there are many provisions within the Administrative Simplification Section of HIPAA, the information below will be limited to the area that will have the most impact on you as a physician – the Patient Privacy provisions.

Patient Privacy

Prior to HIPAA, there were no comprehensive federal laws to protect the privacy of patient identifiable information, specifically individual's information that is contained in the patient's medical record. Although California has had laws to protect patient's medical information, there were many inconsistencies from state to state. The HIPAA Privacy Laws aimed to fill the gaps in the inconsistent states' laws with new federal laws.

Patient Rights:
The Privacy rules give patients the following rights related to their medical information:

- **The right to inspect and copy their medical records.**
  This means that a patient can view their original record and obtain copies of that record or in some cases, receive a summary of their record. Because this is currently required by California state law, this portion of the regulation will not have a significant impact on LLUMC.

- **The right to request amendments or corrections to their medical record.**
  This means that patients, after reviewing their medical record information, can request changes to any information they feel is in error or may not be complete. The covered entity, e.g., hospital, is not obligated to amend or otherwise update the patient's record if they disagree with the amendment the patient is requesting; however, a detailed process has been put in place to appropriately respond the patient's amendment requests.

- **The right to a notice of information practices.**
  This means that patients have a right to be informed about how a covered entity discloses their protected health information (PHI) and what rights they have regarding their own information. HIPAA also requires a covered entity to notify patients 30 days prior to the implementation of a policy/procedure change related to the disclosure of information. All individuals (except inmates) have a right to receive a notice from any covered entity that communicates their privacy practices. The person does not have to be a patient or customer of a covered entity.

- **The right to an accounting of disclosures.**
  This means that a patient has the right to request and receive an accounting, or listing, of how his or her information was disclosed in the six years prior to the date they requested this information. HIPAA requires that a covered entity "act on" the individual's request "no later than 60 days after receipt of such a request." There is an allowance for a 30 day extension and an entity may not charge a patient for providing this information if it is not requested more often than once every 12 months.

  In order to provide the required accounting of disclosures, it is important that LLUMC's policy regarding the release of patient information, be followed.

  Patient Protections:
  The Privacy rule states that in order for the patient to control "access to" and "disclosure of" his/her protected health information, the patient is provided with the following protections:

  1. The right to specifically authorize the *use* or *disclosure* of their protected health information for purposes other than treatment, payment, or healthcare operations. An authorization must be written in specific terms and allows use and disclosure of PHI for purposes other than those covered by the consent.
     Use – applies to sharing PHI within an entity, e.g., reviewing medical record information with another employee.
     Disclosure – applies to sharing PHI outside of the entity, e.g., reviewing medical record information with a physician from Redlands Community Hospital.

  2. The right to agree or object to certain *uses* or *disclosures* of their protected health information, e.g., *printing the patient's name in the facility directory, disclosure to the clergy, notification of relatives.*

What are you responsible for?

Confidentiality and security of patient identifiable information in any form – verbal, written, and electronic.

Protected Health Information (PHI) is any individually identifiable information, including demographic information, that identifies an individual or where there is a

reasonable basis to believe the information can be used to identify the individual and meets any of or all of the following criteria:

- Is created or received by a healthcare provider, health plan, employer, or healthcare clearinghouse
- Relates to the past, present, or future physical or mental health or condition of an individual
- Describes the past, present, or future payment for the provision of healthcare to an individual

PHI is not limited to health information that is maintained or transmitted electronically. These regulations also apply to information conveyed on paper or via the spoken word.

Examples:
Computer databases
E-mail
Phone
Dictation
Faxes
All patient records (including notes on PDAs, clipboards, etc.)
Rounds
Case Conferences
Elevators
Dinner Table

No one other than one whom is directly involved with a patient's care is to have access to the patient's record or information of any kind regarding his/her treatment.

How do we protect information?

Establish a "need to know" before discussing patient confidential information with anyone.

Prevent access to information by unauthorized persons:

- Log off computers
- Protect your computer access password; do not give it out
- Clear your work or desk area of all papers before leaving
- Do not discuss confidential information in areas where it can be overheard
- Be cautious in providing information requested by phone callers
- Properly discard paperwork that contains confidential information
- Establish a need to know before discussing patient information

Penalty for Violations

The risks of non-compliance with the HIPAA regulations vary depending upon the type of violation and depending upon whether or not it is determined that the violation was intentional or unintentional.

Penalties for unintentional violations:

- Fines of $100 per violation, up to a total of $25,000 per year

Penalties for intentional violations:

- Fines of up to $50,000 and/or imprisonment of up to one year
- Fines of up to $100,000 and/or imprisonment for up to 5 years if the violation is committed under “false pretenses”
- Fines of up to $250,000 and/or imprisonment for up to 10 years if the violation is committed with the intent to sell, transfer or use individually identifiable information for commercial advantage, personal gain, or malicious harm.

LOMA LINDA UNIVERSITY MEDICAL CENTER
LOMA LINDA UNIVERSITY CHILDREN'S HOSPITAL
LOMA LINDA UNIVERSITY COMMUNITY MEDICAL CENTER

STAFF DEVELOPMENT

Staff Development Competency Series

INFORMATION SECURITY AND CONFIDENTIALITY

LLUMC Policies Associated With This Competency

For a comprehensive list of LLUMC Policies related to Information Security and Confidentiality, please see the section at the end of this Competency.

The Importance of Confidentiality

As an employee of Loma Linda University Medical Center (LLUMC), you are entrusted with confidential information of all types. With this trust comes the responsibility and obligation to ensure that the information is used only for its intended purpose. Because patients and family members place a tremendous amount of trust in us, we face ever-increasing scrutiny of the measures we take to ensure confidentiality. Any misuse of confidential information or violations of our confidentiality policies could destroy our patients' trust in us, and impact our employees' ability to do their jobs.

Virtually every department and unit must be held to the utmost of security and confidentiality. And while most employees do not have access to all information, all information obtained and handled as part of every job done in our institution must be considered to be **confidential**. Thus the responsibility to acknowledge and maintain information security and confidentiality applies to **all** employees and volunteers.

In fact, everyone who begins work in our institution is required to sign a **Confidentiality Statement.** By signing the form the employee agrees not to disclose, or discuss, confidential information with anyone unless administratively approved and necessary during the course and scope of his/her employment. We have the same expectations for physicians, business partners, and any other person working for us in or out of the Medical Center.

Confidentiality And The Law

Certain federal and state laws require that information is correct and used appropriately. These laws protect a person's right to privacy; prohibit violations of copyright, patents, and trade secrets; and prohibit unauthorized computer access to certain types of information. California also has specific regulations concerning several categories of patient information such as mental health records, victims of violent crime, and HIV status.

- California Code, Title 22, section 70707 on patient rights, declares that a patient has the right to confidentiality of all communication and records pertaining to his or her care and hospital stay.

- California Welfare and Institutions Code, section 5328, states that disclosure of any information about psychiatric and/or substance abuse patients is prohibited. In part, this means that healthcare providers caring for these types of patients cannot disclose whether or not the person even exists as a patient in these kinds of facilities.

◆ California Civil Code, section 56.16, "allows hospital personnel to release patient information at their discretion." However, LLUMC has adopted its own policy of cooperation with the news media. Since September of 1991, "in the interest of safety for the patient and the hospital staff, the Medical Center has imposed confidentiality on all victims of violent crime. The patient's name [should] not even appear on the hospital census." In fact, **no information of any kind** should ever be given to the media by an unauthorized LLUMC employee.

◆ California Evidence Code, sections 990-1007, describes "Physician-Patient Privilege." All conversations between a patient and his or her physician, and any conversations overheard regarding any other patient, are considered strictly confidential. This mandate is also true of written patient information.

◆ California Civil Code, section 56.10, discusses our responsibility to maintain the "Confidentiality of Medical Information." It describes the **only** situations in which disclosure of medical information by healthcare providers is appropriate, and only then to **authorized** individuals involved in the situation:

- Diagnosis and treatment
- Billing or payment
- Emergency care and communication
- Investigation
- Arbitration
- Accreditation
- Litigation
- Research

Types & Forms of Information

There are many types and forms of information that must be protected from loss, unauthorized changes, and disclosure. The following are examples of the types of information needing protection:

- Patients' medical records and charts – this includes medical information about employees who are also patients and the information below:
  - Patients' medical history
  - Patients' diagnoses and treatment
  - Patients' laboratory results
  - Patients' financial information
- Information in a patient's file regarding family matters
- Medical Center committee communications
- Medical Center financial information
- Medical Center compensation/salary information
- Scientific or medical research information
- Information contained in employees' personnel files (in HRM and/or department/unit files)

Information is one of our most valuable assets, and can appear in many forms, including the examples below. Each employee is responsible to protect information and maintain confidentiality, **whether or not** they work directly with patients.

- Conversations
- Computer records
- Word processing documents
- Recyclable trash
- Letters, memos, and reports
- Diskettes, microfilm and microfiche

Protecting Information

It is easy to become careless about the information we handle in our work area because we have authorized access to this information. But just as we should familiarize ourselves with LLUMC procedures and fire safety rules, we need to know what to do to protect ourselves and others from a breach of confidentiality and/or break in information security. It is even more important to prevent access by **unauthorized** persons. Here are some ways to protect the security and confidentiality of information:

- Be very cautious in providing information requested by phone callers
  - Verify the identity of the caller if possible – if not possible tell the caller you will call them back
  - Verify the caller's need to know the requested information – refer any unusual requests to a supervisor
  - DO NOT give out any unauthorized information – if you are not sure…ASK your supervisor
  - Be aware of other people in the area who could overhear your conversation

- Protect computerized information from general viewing and unauthorized access

- Protect your computer access password
  - DO NOT share it with anyone
  - Immediately change a password you suspect may have been stolen
  - Sign-off or log-off when you have completed your computer tasks

- DO NOT discuss confidential information in areas where it can be overheard
  - Inside or outside of cafeterias
  - Inside of, or waiting for, elevators
  - In patient waiting areas or on the phone in general access hallways or meeting rooms

Additionally you must:

- Establish "need-to-know" before discussing information with co-workers and others
- Politely challenge unauthorized visitors or other curiosity-seekers
- Appropriately label confidential or sensitive documents
- Clear your work or desk area of all papers at the end of the day
- Lock sensitive documents in a drawer, cabinet, or safe (if available) – keep the access keys hidden
- Properly discard any paperwork that contains confidential information – such as shredding

AND REMEMBER…

- DO NOT access any information (including computerized, written or otherwise) about other employees, patients who are also employees, or your own family or friends who are also patients **(breaches of information security and confidentiality of this type are the most common).**

Protecting Computer Information

Computers are used throughout the institution to input, print out, change, re-arrange, and store all kinds of information as noted in the previous sections. If you have computer access, your password gives you access to multiple sources of information, and is intended for your work use only. **You are responsible for any access made under your user ID and password.** If you work with a computer system, here are some of the ways you can protect both the computerized information and your password access to this information:

- Make sure that anyone using a computer terminal in your area is authorized to do so
- When confidential or sensitive information is on the screen, be sure that no one else can view or see it
- Be sure to sign-off or log-off when you leave the computer terminal, or you have completed your computer tasks…even if you plan to return to the computer, or continue to work in just a moment
- Protect your password
  - DO NOT allow anyone to borrow it, even once
  - Change your password periodically
  - Change your password immediately if others now know it
  - Choose hard-to-guess passwords
  - Enter your password in private
- ONLY access computerized information that is necessary for your job tasks…**this does not include access of information for personal use or curiosity.**
- If you need to allow someone access to your computerized information while you are away or on vacation, arrange for your supervisor to access the information.

Internet Useage

Computer usage may include the need to access internet Web sites for the purpose of research, etc. While "Web browsing" can be an important and necessary task in your position, it is vital to understand your responsibilities when accessing these sites.

- You are responsible for all transactions, including browsing, that take place while you are signed on to the computer under your computer access password.
- Browsing the Internet and/or Web must be limited to that necessary for your job.
- Web sites that contain any form of pornography must be avoided (and especially not attached to e:mail messages). If these sites are accessed and viewed for a length of time, you may be subject to disciplinary action up to, and including, termination from the job.

Employees As Patients

A person's treatment and recuperation are very private matters. Even a well-meaning intrusion is a breach of confidentiality unless the person has indicated that visits, cards or calls are welcome. Unless you know for sure that a co-worker wants attention, you must respect and maintain the information security and confidentiality of that employee. Not doing so may cause stress or embarrassment to the employee patient.

This policy also applies to celebrities we may have as patients in our institution. As professionals, we owe it to these patients not to intrude upon their privacy and in their personal lives. To care for these patients is a privilege, not a right.

Breaching Information Security/Confidentiality - Examples

Contrary to what you might think, most information security and confidentiality breaches are NOT due to criminal intent. In general, most are due to carelessness, sometimes even due to good intentions. Please read through the following examples:

1. You are standing in line in the cafeteria when a colleague walks past. The colleague is a person knowledgeable about a treatment you are using with a patient, so it is a good opportunity to discuss questions you have regarding this treatment. You begin discussing your patient's treatment in this very public place. **This is a clear breach of confidentiality…even if a patient's name is never mentioned.**

2. You loan a computer disk to a person in another office, forgetting that there is information on the disk which details a personnel problem you are having with a colleague. Even if the person to whom you have loaned the disk does not access the file, **information security and confidentiality has been breached** by not appropriately labeling and storing the sensitive information.

3. At a party in your neighborhood, someone mentions that a famous entertainment personality is in the Medical Center for tests. They share the fact that this person smokes, which is surprising given his public support of a nationwide non-smoking campaign. To share the patient's name is **the first breach of confidentiality**. To share the patient's health information is **the second breach of confidentiality.**

4. As you are emptying a recycle trash bin, you notice some information about an employee who is about to be terminated due to scandalous circumstances. You stop to read the information about this termination process. The person who "threw away" this information should have taken greater care in destroying highly sensitive information. **This is the first breach of information security and confidentiality.** However, just because information is thrown away, does not mean it is available for reading. **This is the second breach of information security and confidentiality.**

Breaching Information Security/Confidentiality – Taking Responsibility

Inappropriate use and/or disclosure of confidential information is not only harmful to patients and the Medical Center, it will result in disciplinary action up to, and including, termination from the job. Whether you work on the facility grounds, with paper records, on a computer terminal, or spend most of your day on the phone or with patients, you are part of the Medical Center's information security and confidentiality system.

If you should observe or overhear a breach of information security and confidentiality, you should first mention it to the people/person involved – they may not realize what they are doing. If this does not help, it is important to immediately inform your supervisor, manager, or the Information Systems Security Administrator. Remember that each of us is responsible for maintaining information security and confidentiality.

Policies Associated With This Competency

Per LLUMC Policy A-49, "the following related documents, policies and procedures shall be used for further and specific guidance for information security at the Medical Center." Please see the next page for the start of the list.
NOTE: Many of these policies may have changed.

GENERAL MANAGEMENT

• A-7 Retention of Documents	• A-24 Subpoenas, Depositions, Witnessing
• A-9 Release of Patient Information to News Media	• A-27 Inventions, and Patents – Intellectual Properties
• A-10 Confidentiality of Patient Information	• A-41 Contract and Document Control
• A-19 Publications	• A-42 Fax Security
• A-22 Photography	• A-43 Use of Computer Internet Services
• A-23 Political Activities	• A-44 Videotaping/Media Materials Production in the Medical Center
FINANCE	
• C-1 Authorization for the Expenditure of Funds	• C-11 Asset Trade-In
• C-2 Transfer of Authorized Signature Power for Expenditure of Funds	• C-12 Leases – Medical Center as Lessee
• C-3 Operating Budget	• C-13 Leases – Committing the Medical Center as Lessor
• C-4 Budget Variances	• C-18 Cash management and Investment
• C-6 Notes Payable	• C-21 Maintenance Agreements Authorization
• C-10 Restricted Fund Expenditure processing	
MEDICAL RECORDS	
• D-1 Faxed Medical Information Material	• D-6 Authentication of Medical Records
• D-2 Use of Rubber Stamp Signatures on Medical Records	• D-8 Release of Patient Records to State Agency Representative
• D-3 Medical Record Completion Requirements	• D-10 Documentation
• D-4 Control of Medical Records	• D-11 Composition of Medical Records
• D-5 Review of Patient Records by Third Party Payors/Reviewers	
HRM MANAGEMENT	
• I-8 Performance Review	• I-25 Personnel Records
• I-11 Grievance and Arbitration	• I-45 Release of Employee Telephone and Address Information
CLINICAL MANAGEMENT	
• M-8 Suspected Child Abuse/Neglect	• M-34 Events Involving Patients
• M-9 Nursing Process and Documentation	• M-65 Pre-Operative Assessment
• M-13 Police Cases – Rights of Patients and Responsibilities of Personnel	• M-100 Authorization for Treatments of Minors Who Lack Capacity to Consent
• M-18 Sterilization Consent Requirements and Responsibilities of Personnel	• M-105 Victims of Adult/Spouse/Partner Abuse and/or Physical Abuse
• M-19 Determination of Brain Death	• M-108 Victims of Adult Rape or Other Sexual Molestation
• M-23 Disposition of Bodies, Body Parts, and Fetal Remains	
ADMISSION/DISCHARGE/TRANSFER/PLACEMENT	
• O-1 Patient Admission, Placement, and Assignment of Care	• O-17 Patient Admissions To LLUMC
PATIENTS' RIGHTS	
• P-1 Patients' Rights and Responsibilities	• P-8 Consent for Emergency Treatment
• P-2 Patient Consent	• P-9 Rights and/or Responsibilities of Pediatric Patients, Parents/Guardians
• P-4 Code Status/Limitation or Treatment for Adults	• P-10 Adult Patient Rights regarding Advance Directives and Acceptance/Refusal of Medicine
• P-5 California Natural Death Act Declaration	• P-11 Survey of Patient Satisfaction
• P-6 Personal Access to Medical Records	• P-13 Patient Complaints
• P-7 Lanterman-Petris-Sort (LPS) Conservatorships	
PROFESSIONAL PRACTICE	
• Q-4 Human Studies	• Q-10 Organ/Tissues Donations
• Q-6 Autopsy Requirements	• Q-14 Standardized Practices
• Q-9 Employees witnessing Signatures on Patients' Personal Legal Documents	
PHARMACY	
• R-1 Investigational Drugs	• R-8 Drug Reference Materials on Nursing Units
• R-2 Evaluation of Non-Formulary Medications	• R-18 Patient Instructions for Outpatient Medications
• R-3 Medical Center Drug Formulary	• R-21 Processing Physicians Intravenous Orders
• R-5 Controlled Substances	• R-24 Narcotics and Controlled Drugs – Management in Patient

	Care Areas
OTHERS	
• Medical Staff Bylaws	• Information Security Handbook
• Department Policies and Procedures	• Other applicable LLUMC policies and procedures

Developed in 2000 by Gwendolyn A. Wysocki, RN, C, MN from a handout entitled, "Confidentiality and Information Security," LLUMC. Original author and date unknown. Assistance for revisions gratefully provided by: Helen Staples-Evans, Administrative Director, Staff Development; Renee Hills, Executive Director, Quality Resource Management; Joy Guy, Clinical Educator, Staff Development; Anita Rockwell-Hayden, Director, Community Relations; Alvin Siagian, Information Systems Security Administrator; David L. Wysocki, Esq., Aklufi and Wysocki.

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INFORMED CONSENT PROCESS

What is Informed Consent?

It is the duty of the physician to disclose to the patient all material information necessary to enable the patient to make an informed decision regarding the proposed operation or treatment. Material information is that information that would be regarded as significant when deciding to accept or reject a recommended medical procedure.

When a procedure inherently involves a known risk of death or serious bodily harm, it is the physician's duty to disclose to the patient the possibility of such outcome and to explain in lay terms the complications that might possibly occur.

In other words, the concept of informed consent is premised upon the general principle that prior to treatment, the physician has informed the patient of the nature of the procedure, the risks and complications, the procedure's expected benefits or effects, and any alternatives to the treatment and their risks and benefits.

Who May Give Consent?

- Adult patient deemed competent
- Legal guardian or conservator for adult patient deemed incompetent
- Parent, legal guardian (with guardianship papers) for minor patient

When is Consent Necessary?

- General Rule
  The Medical Center may not permit any treatment, without the risk of liability, unless the patient, or a person legally authorized to act on the patient's behalf, has consented to the treatment.

- Emergency Treatment
  In the case of a medical emergency, treatment may proceed without the patient's consent as long as no evidence exists to indicate that the patient (or legal representative) would refuse the treatment. Examples are:

  - Immediate service is required to alleviate severe pain.
  - Immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated.

What is the Duration of a Consent?

- The consent stays in effect until the patient revokes his/her consent; OR
- Circumstances change, materially affecting the nature of the risks, benefits, alternatives to which the patient has consented.

How is the Consent Process Documented?

Discussion regarding the procedure, risks, benefits, alternatives (informed consent), should be documented on the "Informed Consent Progress Note." (See attached.) If use of blood is anticipated for the procedure or if a type and screen or type and cross is done, the blood transfusion informed consent must be documented on the back side of the "Informed Consent Progress Note." This documentation meets the legal requirements of the Paul Gann Blood Safety Act. Both documentations must be done by the attending physician or resident who will be performing the procedure or treatment.

The patient will then sign the "Informed Consent Progress Note" and the "Blood Transfusion Informed Consent" forms. If the procedure is an emergency in which the patient's signature cannot be obtained, documentation on the same form will include the procedure performed and the reason the procedure was necessary and will be accompanied by the signature of a licensed physician.

The patient is also required to sign a procedural consent form which will then be witnessed by a Medical Center employee, not the physician (see attached).

National Patient Safety Goals

The Institute of Medicine (IOM) produced a report in 1999 announcing that 44,000 to 98,000 people are seriously injured or die as a result of healthcare errors. As a result of the report "To Err is Human," many regulatory and accrediting agencies have focused on patient safety. To protect patients, processes and systems are developed to prevent healthcare workers from making mistakes.

There are seven National Patient Safety Goals. Described below are the goals and how LLUMC is meeting these goals. It takes compliance by every employee, housestaff member, and medical staff member to support our patient safety program.

1) Improve the accuracy of patient identification

    - Two patient identifiers (medical record number and patient name for inpatients) are used whenever taking blood samples or administering blood or medications.
    - A "time out" process is performed by the physician/surgeon, anesthesia provider (as applicable), and circulating nurse prior to the start of surgery or procedure. This is a process using active communication to verify correct patient, the correct procedure, the correct site and side of the procedure, and, as applicable, implants.

2) Improve the effectiveness of communication among caregivers

    - Verbal and telephone orders are verified using the *read back (not repeated back)* process by the person receiving the order. A critical test result is also "read back" to verify its accuracy.
    - Do not use the abbreviations, acronyms, and symbols from the posted list of unacceptable abbreviations. The list is also found in the physicians order section of the patient's chart.

3) Improve the safety of high alert medications

    - Concentrated electrolytes have been removed from patient care areas.
    - There is an ongoing effort to standardize and limit the number of drug concentrations available, both adults and pediatrics.

4) Eliminate wrong-site, wrong-patient, wrong-procedure surgery.

    - Along with the "time out" process, a preoperative checklist is used by Medical Center staff to confirm that the appropriate documents are available for verification of correct patient and procedure.
    - When laterality or digits are involved, the site must be marked with an indelible pen by the surgeon, patient, or legal guardian.

5) Improve the safety of using infusion pumps.

- All infusion pumps at LLUMC have free-flow protection.
- Adding minimum/maximum dosing protection to infusion devices is an ongoing project.

6) Improve the effectiveness of clinical alarm systems.

- All alarm systems receive preventive maintenance on a scheduled basis and are tested accordingly. This includes cardiac alarms, ventilator alarms, and the infant abduction alarms.
- Alarms must be set with reasonable parameters and must be audible to caregivers.

7) Reduce the risk of healthcare-acquired infections

- The CDC hand-hygiene standards have been implemented including the use of alcohol-based hand rub products if hands are not soiled. Artificial/acrylic nails are prohibited for employees and medical staff with direct and indirect patient care responsibilities.
- All identified cases of unanticipated deaths or major permanent loss of function associated with a nosocomial infection are managed as a sentinel event.

Your cooperation and involvement in meeting these goals will help make our Medical Center safe for our patients.

PATIENT RIGHTS

Federal and state laws as well as accreditation standards provide for a listing of rights that every patient is entitled to. Patients and their families have become acutely aware of their rights and as mandated by law, each patient is given a copy of these rights upon admission. The patient rights working provided to patients is listed below.

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your personal values and beliefs.

2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the Medical Center.

3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.

4. Receive information about your health status, course of treatment and prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.

5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.

6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the Medical Center even against the advice of physicians, to the extent permitted by law.

7. Be advised if the Medical Center/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.

8. Reasonable responses to any reasonable requests made for service.

9. Appropriate assessment and management of your pain.

10. Formulate advance directives. This includes designating a decision-maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Medical Center staff and practitioners who provide care in the hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.

11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.

12. Confidential treatment of all communications and records pertaining to your care and stay in the Medical Center. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.

13. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.

14. Be free of restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.

15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.

16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the hospital. Upon your request, a friend or family member may be provided this information also.

17. Know which hospital rules and policies apply to your conduct while a patient.

18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    - No visitors are allowed.
    - The Medical Center reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the Medical Center.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, the Medical Center may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

19. Have your wishes considered, if you lack decision-making capacity, for the purpose of determining who may visit. The method of that consideration will be disclosed in the Medical Center policy on visitation. At a minimum, the Medical Center shall include any persons living in your household.

20. Examine and receive an explanation of the Medical Center's bill regardless of the source of payment.

21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status or the source of payment for care.

22. File a grievance. If you want to file a grievance, you may do so by writing or by calling the Administrative Patient Representative.

23. File a complaint with the state Department of Health Services regardless of whether you use the hospital's grievance process.

Preventing Sexual Harassment
In The Workplace

Importance of Sexual Harassment Prevention:

- Sexual harassment is prohibited by *law*.
- Sexual harassment is prohibited by *organization policy.*
- Sexual harassment is an *abuse of power, respect, and trust.*
- Sexual harassment can result in *emotional and physical harm.*
- Sexual harassment reduces *productivity.*
- Sexual harassment diminishes *staff morale*.
- Sexual harassment can result in *costly litigation or lawsuits.*

The Law:

Title VII of the Civil Rights Act of 1964 mandates that every employee has the legal right to work free from harassment on the basis of sex. Sexual harassment is a form of discrimination.

The Policy:

- Loma Linda University Medical Center Medical Staff Bylaws refer to section 3.2-4.
- Loma Linda University Medical Center refer to policy I-39.
- Loma Linda University Health Care refer to policy HR-27.
- Loma Linda University Behavioral Medicine Center refer to policy BI-25.
- Loma Linda University refer to policy I-15.

In summary, all policies advocate zero tolerance.

Sexual Harassment Defined:

The Equal Employment Opportunity Commission's Sex Discrimination guidelines define sexual harassment as *unwanted, unwelcomed sexual advances, requests for sexual favors*, and other *verbal or physical conduct of a sexual nature* when

- submission to conduct is made either explicitly or implicitly a condition or a term of an individual's employment;
- an employment decision is based on an individual's acceptance or rejection of that conduct; or
- such conduct interferes with an individual's work performance or creates an intimidating, hostile, or offensive working environment.

Factors considered in determining sexual harassment:

- Was the behavior unwelcome?
- How often did it occur?
- Was the behavior blatant?
- How would a reasonable person view the experience?
- Was this a single incident or a series of incidents?
- Does the individual belong to a protected group?
- Was the behavior based on sex?
- Was it a term, condition, or privilege of employment?
- Was the action known about or should it have been?

Two Types of Sexual Harassment:

1) Quid Pro Quo: ("this for that" or "in exchange for") Is created when job or job benefits are contingent on sexual conduct or favors.

2) **Hostile Environment:** Is created through the following types of gender specific behaviors.
   - Verbal - jokes, threats, offensive language
   - Nonverbal - staring, gestures, suggestive pictures or cartoons
   - Physical - holding, hugging, kissing, grabbing, brushing, preventing movement
   - Third party harassment - *For example:* An employee is embarrassed after overhearing other employees talk about their personal love relationships.

Important facts about sexual harassment:

- What is sexual harassment to one person in one set of circumstances is not necessarily sexual harassment for someone else.
- A man as well as a woman may be the recipient of sexual harassment, and a woman as well as a man may be the offender.
- The recipient does not have to be of the opposite sex from the offender.
- The recipient does not have to be the person at whom the unwelcome sexual advances are directed.
- There is no legal requirement that the recipient complain to the offender or report sexual harassment to his or her supervisor in order for the employer to be held responsible.
- Unlawful sexual harassment does not depend on the recipient having suffered a concrete economic loss. If the harassment has interfered with the recipient's work performance or has created an offensive work environment, sexual harassment has occurred.
- Like rape, there is nothing "sexy" about sexual harassment. Sexual harassment is an abuse of power.
- Retaliation against a recipient of harassment is considered a serious offense by enforcement agencies.

REMEMBER!! RETALIATION WILL NOT BE TOLERATED!!

Guidelines to Prevent Sexual Harassment:

- Separate personal and business relationships.
- Make objective decisions.
- Avoid compromising situations.
- Do not touch co-workers.
- Console with your words, not hugs.
- Do not discuss your sex life at work.
- Call people by their name.
- Do not tell jokes that are gender-specific or sexual in orientation.
- Use your normal tone of voice.
- Be aware and sensitive to ethnic diversity.
- Do not expect someone to tell you when your actions make him or her feel uncomfortable.
- Provide feedback on performance.
- Do not accept excuses for inappropriate behavior.
- Set an example and always take action when you see something that constitutes sexual harassment.

In summary, treat people with respect and dignity. If you would not want your father, mother, brother, sister, or spouse treated in that manner, then do not say it or do it.

Available Resources:

Human Resource Management (HRM)	558-4141 or ext. 44141 558-4345 or ext. 44345
Employee Assistance Program	799-6050 or ext. 66050

Handout Resources

1. Johnston E. Joni, Psy.D. "Before it gets to court: Effective EAP input in handling harassment incidents." Employee Assistance. July 1994.

PROCEDURE RELATED SEDATION

Outline

I Introduction

II Definitions: The 5 Levels of Sedation and Anesthesia

III Emergency Procedures, Critical Care Areas and Policy Exclusions

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V NPO: The Timing of Eating and Drinking before Sedation

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IX Post-Procedure Monitoring and the PAR Score

X Discharge Criteria and Concluding Post-Procedure Monitoring

PROCEDURE RELATED SEDATION

Lance Brown, MD, MPH

I. Introduction

The purpose of this tutorial is to familiarize the reader with the Loma Linda University Medical Center Policy M-86 for Procedure Related Sedation. Procedure related sedation is used to make necessary medical procedures as comfortable as possible for patients and to facilitate the performance of necessary medical procedures by health care providers (typically physicians). It is important for health care providers performing procedure related sedation to be familiar with the pharmacologic characteristics of the agents being used, to understand the risk factors for complications related to procedure related sedation, and to individually plan the sedation for each patient. Each health care practitioner privileged to provide procedure related sedation takes responsibility for both the **comfort and safety** of the patients in their care.

II. Definitions

At Loma Linda University Medical Center, we have defined five distinct levels of sedation and anesthesia. Familiarity with the definitions of these levels of sedation is important for safely providing procedure related sedation and for complying with the policy of the Medical Center. It must be recognized, however, that sedation occurs along a continuum and that individual patients may have different degrees of sedation for a given dose and route of medication. Although one level of sedation is planned, a patient may unexpectedly progress from lighter sedation to deeper sedation. Each health care practitioner involved in providing procedure related sedation must be prepared at all times during the sedation to promptly and safely manage a patient who has unexpectedly become sedated beyond the planned level of sedation. The definitions are as follows:

1. Minimal Sedation (Anxiolysis):
Minimal sedation has been achieved when a patient enters a drug-induced state during which he/she responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Minimal sedation is planned using a single agent regardless of route. Midazolam, in particular, may be used for minimal sedation.

Although care should be individualized for each patient and circumstance, the following patients may be considered inappropriate candidates for minimal sedation:

- Known or suspected abnormal airway anatomy
- Suspected or known oral or neck mass that may impede necessary airway management
- Prior history of failing minimal sedation

NOTE: If a combination of drugs is used to facilitate a procedure, the patient is, by definition, undergoing moderate, dissociative, or deep sedation. In other words, if two or more drugs are being used to facilitate a procedure, the health care provided **cannot** claim to be providing minimal sedation.

2. Moderate Sedation/Analgesia:
Moderate sedation/analgesia has been achieved when a patient enters a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (reflex withdrawal from a painful stimulus is considered a purposeful response) either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep Sedation/Anagesia:
Deep sedation/analgesia has been achieved when a patient enters a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

4. Dissociative Sedation:
Dissociative sedation is a trance-like cataleptic state induced by the dissociative agent ketamine (alone or in conjunction with small doses of a benzodiazepine) characterized by profound analgesia and amnesia with retention of protective airway reflexes, spontaneous respirations, and cardiopulmonary stability.

5. General Anesthesia
General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

III. Emergency Procedures, Critical Care Areas and Policy Exclusions

There are certain circumstances in which the Medical Center policy for procedure related sedation does not apply. These exclusions are defined in the Medical Center Policy on Procedure Related Sedation.

First, the use of sedatives for mechanically ventilated (e.g., intubated) patients undergoing procedures in the intensive care units or Emergency Department is excluded from the Medical Center Policy for Procedure Related Sedation. These patients are often critically ill, are already being carefully monitored, have a protected airway, are not eating, have no expectation of being discharged at the conclusion of their procedures, and

undergo frequent procedures as part of what could be considered their "routine" care in these critical care areas. However, if a mechanically ventilated patient leaves these critical care areas for a procedure that is not an emergency or life saving procedure (e.g., a magnetic resonance imaging study), then the Medical Center Policy **does** apply.

Second, the use of sedative drugs to facilitate emergency and life saving procedures is specifically excluded from the Medical Center Policy for Procedure Related Sedation. The urgency with which emergency and life saving procedures typically need to be performed may make it impossible to meet all of the criteria of the policy prior to starting the sedation and performing the procedure. The risks and benefits need to be weighed by the responsible health care provider in each individual circumstance.

Third, the use of anxiolytics (e.g., a medication to relieve anxiety) or analgesics (e.g., a medication to relieve pain) for purposes other than to facilitate a procedure is excluded from the Medical Center Policy for Procedure Related Sedation. Procedure-related sedation must, by definition, involve a procedure. For example, if a patient is given a pain medication for a headache, the administration of this pain medication is not covered under the Medical Center Policy for Procedure Related Sedation because an analgesic was administered to relieve pain, not to facilitate a procedure. However, if this same patient is given sufficient pain medication to make them drowsy (e.g., a drug-induced depression of consciousness during which the patient responds purposefully to verbal commands accompanied by light tactile stimulation) in order to facilitate getting a computed tomographic (CT) scan of the head, then the Medical Center Policy for Procedure Related Sedation **does** apply.

IV. The Pre-Sedation Assessment

Each patient who will be undergoing procedure related sedation must undergo a pre-sedation assessment **immediately** prior to the administration of the medication(s). If the patient has recently undergone an outpatient evaluation in preparation for a procedure, a re-assessment must be performed immediately prior to the administration of the medication(s). The components of a pre-sedation assessment or re-assessment **must include all of the following:**

a. History and physical examination (focusing on risk factors for complications of sedation
b. Procedural indication (why the procedure is being performed)
c. Assessment of the American Society of Anesthesiologists (ASA) physical status classification (see Table 1)
d. NPO status (see Section V of this tutorial: "NPO: The Time of Eating and Drinking Before Sedation")
e. History of allergies
f. History of prior adverse events during sedation, if any
g. Plan for sedation

h. Documentation that the risks, benefits, and alternatives to the planned sedation have been discussed with the patient, parent, or legal guardian of the patient, as appropriate
i. Acknowledgement of informed consent.

In addition, the patient, procedure, and site if laterality or digits involved shall be accurately identified immediately prior to the administration of sedation.

Table 1 ASA Physical Status Classification

ASA Physical Status Classification – a classification system designed by the American Society of Anesthesiologists (ASA) to provide a general description of a patient's physical status. It is used as a preassessment tool to determine a patient's suitability for sedation and/or analgesia. Each clinician should be able to assign an ASA class to each patient. If patients are a physical class 3 or above, consultation with an anesthesiologist should be considered.

Class	Description	Examples	Suitability for Sedation
1	A normal healthy patient		Excellent
2	A patient with mild systemic disease	Heart disease that slightly limits activity, essential hypertension, diabetes, anemia, obesity, chronic bronchitis	Generally good
3	A patient with severe systemic disease	Heart disease that limits activity, poorly controlled hypertension, diabetes with vascular complications, chronic pulmonary disease that limits activity, angina, history of myocardial infarction	Increased risk – consider benefits relative to risks
4	A patient with severe systemic disease that is a constant threat to life	Congestive heart failure, unstable angina, advanced pulmonary, renal, or hepatic disease	Poor – consider benefits relative to risks
5	A moribund patient who is not expected to survive	Ruptured abdominal aneurysm, cerebral trauma, massive pulmonary embolus	Extremely poor
E	Patient requires emergency procedure	Appendectomy, Dilatation and Curettage for uncontrolled bleeding	Not applicable

NOTE: Patients undergoing emergency procedures shall be designated class E in addition to a classification 1 through 5.

V. NPO: The Timing of Eating and Drinking Before Sedation

The decision of *nil per os* (NPO) status should be made by the responsible health care provider who has weighed the risks and benefits of procedural timing on a case by case basis. There are currently no evidence-based guidelines available. There have been, however, consensus-based guidelines published (Anesthesiology 1999; 90: 896-905) that give some guidance based on the nature of the food and drink ingested.

For elective cases performed on healthy individuals, the following guidelines are presented in the Medical Center Policy for Procedure Related Sedation:

a. 2 hours if clear liquids have been ingested
b. 4 hours if breast milk has been ingested
c. 6 hours if non-human milk or infant formula has been ingested
d. Longer time periods (at least 8 hours, for example) may be deemed appropriate if fatty or solid foods have been ingested.

For non-elective cases where the NPO period is deemed inadequate by the responsible health care provider, airway protection (e.g., endotracheal intubation) should be considered.

VI. Review of Some Agents Used for Sedation

See Table 2 for a list of some agents used for sedation.

VII. Orders for Procedure Related Sedation

Orders for procedure related sedation are to be written **exclusively** by individuals privileged to administer procedure related sedation.

Orders must specify the name of the medication, the dose, and the route of administration. If multiple doses are planned, the frequency of administration is to be indicated. Sedation medications are frequently titrated for effect. Orders may reflect this.

VIII. Environmental Requirements and Monitoring During Sedation

The location in which procedure related sedation occurs should be one in which the health care provider can work comfortably and in which the patient is comfortable and safe. The Medical Center Policy for Procedure Related Sedation provides a description of those features which all locations must have in order for procedure related sedation to be in compliance with the policy.

The location in which the procedure related sedation occurs must have the following:

a. Adequate lighting to observe the patient and the monitors

b. Adequate power outlets and clearly labeled outlets connected to the Medical Center's emergency power supply
c. Immediate access to emergency numbers including the appropriate Code Team (except in the Emergency Department and intensive care units)

The following equipment must be available before and throughout the sedation process:

a. Oxygen
b. Airway equipment
c. Appropriately sized bag-valve mask
d. Defibrillator
e. Suction equipment
f. Emergency drugs and reversal agents
g. Equipment to monitor the patient's physiologic status including heart rate, respiratory rate, and oxygenation

Although an intravenous line is not indicated for all cases of procedure related sedation, an individual with the skills to establish intravenous access must be immediately available during procedure related sedation.

Two personnel, as a minimum, must be present during the procedure. These two personnel are typically the practitioner privileged to perform the procedure and an assistant competent to monitor designated physiologic variables. One common example of the required personnel would be a physician who initially provides the sedation and then proceeds to perform a procedure while a nurse monitors the patient.

Monitoring requirements are based on the level of sedation that is planned. If a patient unexpectedly progresses to a deeper level of sedation than was planned, the monitoring should be modified to reflect this change. The monitoring requirements include the following:

Moderate sedation monitoring requirements:

a. Continuous pulse oximetry
b. Documentation of pulse oximetry, blood pressure, heart rate, respiratory rate, and level of consciousness before the administration of medication and **every 15 minutes** throughout the sedation and recovery phase.
c. Continuous cardiac monitoring is not mandatory for moderate sedation, but may be appropriate for patients with pre-existing medical conditions.
d. The assistant (usually a nurse) may assist with minor, interruptible tasks.

Deep sedation monitoring requirements:

a. Continuous pulse oximetry
b. Continuous cardiac monitoring

c. Documentation of pulse oximetry, blood pressure, heart rate, respiratory rate, and level of consciousness before the administration of medication and **every 15 minutes** throughout the sedation phase and **every 15 minutes** during the recovery phase.
d. The assistant (usually a nurse) may have no duties other than monitoring the patient.

Dissociative sedation monitoring requirements:

a. Continuous pulse oximetry
b. Continuous cardiac monitoring
c. Documentation of pulse oximetry, blood pressure, heart rate, respiratory rate, and level of consciousness before the administration of medication and **every 15 minutes** throughout the sedation and recovery phase.

Complications and the management of the complications must be documented in the medical record.

IX. Post-Procedure Monitoring and the PAR Score

Since one of the goals of procedure related sedation is to have a patient comfortable throughout an entire procedure, it is expected that the sedation will last longer than nearly all procedures. Because patients remain sedated beyond the time of the procedure, they are still at risk for complications from the sedation and, therefore, must be monitored beyond the time of the procedure.

The documentation for post-procedure monitoring must begin within 5 minutes after the completion of the procedure and include the following:

a. Pulse oximetry
b. Level of consciousness
c. Heart rate
d. Blood pressure
e. Respiratory rate
f. All medications, fluids, and blood products administered
g. Post-procedure complications and the management of those complications
h. Signature of the registered nurse or respiratory care practitioner who was supervising care.

Post-procedure assessments must be performed at least every 15 minutes and may be performed more often if the patient's condition warrants more frequent monitoring.

If the patient is to be transported following a procedure (e.g., returning from the Radiology Department after a CT scan), a person familiar with resuscitation and airway management **must** accompany the patient at all times until the post-procedure monitoring has concluded (see below).

A useful tool for assessing a patient's recovery from sedation is the post-anesthesia recovery (PAR) score (See Table 3). Unless a PAR score cannot be determined (e.g., in a paraplegic or quadriplegic), a score of **at least 8** is to be achieved before post-procedure monitoring may be discontinued. Given that different pharmacologic agents given by different routes have different durations of action for individual patients, there is not single number of minutes for which a patient must be observed. On a case-by-case basis, patients must be monitored for a time period adequate to assure a reasonable likelihood that the patient will not have a delayed medication effect following the completion of the procedure.

Table 3

Post Anesthesia Recovery (PAR) Score
The total scores from Activity, Respiration, Circulation, Neurologic Status, and Color are added to generate the PAR Score. Scores range from 0 to 10.

Activity Points	**Adult Responses**	**Pediatric Responses**
2	Can move 4 extremities	Moves purposefully
1	Can move 2 extremities	Moves to command or light touch
0	Can move 0 extremities	Not moving
Circulation		
2	Able to breathe deeply	Able to breathe deeply
1	Limited breathing	Limited breathing
0	Apnea	Apnea
Circulation		
2	BP $\pm$ 20 Base mmHg	BP $\pm$ 20% Base mmHg
1	BP $\pm$ 20 to 50 Base mmHg	BP $\pm$ 20% - 50% Base mmHg
0	BP $\pm$ 50 Base mmHg	BP $\pm$ 50% of more Base mmHg
Neurologic Status		
2	Fully awake	Fully awake
1	Arousable	Arousable
0	Not responding	Not responding
Color		
2	Normal	$Sa0_2$>95%
1	Pale/blotchy	$Sa0_2$ 90% - 95%
0	Cyanotic/dusky	$Sa0_2$<90%

X. Discharge Criteria and Concluding Post-Procedure Monitoring

Transferring a patient to an unmonitored Medical Center area or to home must be done at a time that is safe for the patient. Even though post-procedure monitoring may have concluded based on the above criteria (See Section IX. Post-Procedure Monitoring and the PAR Score), the patient may not be ready for discharge from the sedation area. For example, a patient who is repetitively vomiting may have recovered from the sedation and yet still not be ready for discharge home.

Once the post-procedure monitoring has concluded, a patient may be transferred to an unmonitored area of the Medical Center if all of the following area met:

a. The patient has been observed for a time period adequate to assure a reasonable likelihood that the patient will not have a delayed medication effect following completion of the procedure.
b. The patient has stable vital signs.
c. The patient has adequate respiratory function or has returned to the pre-procedure/pre-sedation state.
d. The patient's mental status is normal and has returned to the pre-procedure/pre-sedation state.
e. The patient has normal circulation or has returned to the pre-procedure/pre-sedation circulatory state.
f. The patient is free from undue discomfort caused by the procedure and has a reasonable likelihood of having no ongoing bleeding related to the procedure.

Patients who are to be discharged home will no longer be under direct medical care and so must be able to do more on their own. Once the post-procedure monitoring has concluded, a patient may be discharged to home if all of the following are met:

a. The patient has been observed for a time period adequate to assure a reasonable likelihood that the patient will not have a delayed medication effect following completion of the procedure.
b. The patient has stable vital signs.
c. The patient has adequate respiratory function or has returned to the pre-procedure/pre-sedation respiratory state.
d. The patient's mental status is normal or has returned to the pre-procedure/pre-sedation state.
e. The patient has normal circulation or has returned to the pre-procedure/pre-sedation circulatory state.
f. The patient is free of undue discomfort caused by the procedure and has a reasonable likelihood of having no ongoing bleeding related to the procedure.
g. The patient should be able to stand upright and ambulate as appropriate for age and condition.
h. The patient should be able to swallow and retain oral fluids, if appropriate.
i. The patient should be able to void when applicable.

j. The patient has demonstrated an appropriate post-anesthesia recovery score (PARS) (See reference M-86-C and section 7.5 of Medical Center Policy M-86).
k. Appropriate discharge instructions (based on the procedure performed, the medications administered, the patient's underlying medical conditions, the patient's age, and the outpatient follow-up plans) have been provided to the patient, parent or legal guardian of the patient as appropriate.
l. The patient shall be instructed not to operate a motor vehicle for 24 hours.
m. The patient will be discharged directly to the supervision of an adult sponsor who will accompany the patient to his/her home or place of lodging.

Hopefully, by following our Medical Center Policy for Procedure Related Sedation, we can provide the most comfortable and safe environment possible for our patients.

RESTRAINTS AND HOW TO ORDER

Loma Linda University Medical Center acknowledges the inherent dignity of the individual patient and supports his or her right to be free from restraints unless medically necessary/clinically justified. The following highlights regarding restraints will help you comply with the regulatory requirements set forth by the various regulatory agencies and LLUMC policy. Refer to Policy M-91 for detailed information.

Physical restraint is the use of a physical or mechanical device to involuntarily restrain the movement of the whole or a portion of a patient's body for the reason of controlling his/her physical activities in order to protect him/her or others from injury.

Restraints for Medical Management: Must be medically necessary/clinically justified in the provision of acute medical/surgical care: a) to prevent interference with medical treatment or use of equipment and devices; b) to minimize risk of injury/harm to self or others; and c) are <u>not</u> in response to unanticipated, severely aggressive and/or violent behavior. Restraints for medical management do not apply to medical immobilization (customary mechanisms used during procedures/tests), adaptive support, protective devices, and forensic restrictive devices such as handcuffs.

Restraints for Behavior Management: Apply to emergency situations where unanticipated, severely aggressive, destructive, or violent behavior places the patient or other in imminent danger.

<u>Ordering Restraints</u>

- Less restrictive alternatives must have been determined to be contraindicated, ineffective, or insufficient to protect the patient or others from injury and documented.

- A face-to-face assessment must be performed and documented by a physician within 24 hours from initiation of restraint and at least every 24 hours thereafter if restraints are still required (see guidelines below for the requirements for restraints for behavior management).

- Restraint order shall be written on the restraint order form and shall:
  - Specify the type of restraint and reason for use.
  - Include ordered date and time.
  - Limit restraint use to periods no longer than 24 hours (for behavior management, see below).
  - Be given within the same shift as emergency application of the restraint.
  - Be authenticated within 24 hours if given as a telephone order.

- Be re-written for any episodes occurring beyond the time limit established in previous orders. Orders to continue restraints for medical management after the initial period cannot be given as telephone orders.

For Behavior Management – in addition to the above:

- Duration shall be limited as follows: 4 hours for adults, 2 hours for children and adolescents ages 9 – 17, 1 hour for children under the age of 9.
- A licensed physician must perform a face-to-face assessment within 1 hour of restraint initiation and then every 8 hours for patients 18 years of age and older or every 4 hours for patients 17 years of age and younger if restraints are still needed.

Documentation

- Restraints must be accompanied by a written modification to the plan of care. The physician documentation should include findings from the face-to-face assessment related to why the patient requires restraints and how the underlying reason for the patient's need for restraints will be managed.

MEDICAL STAFF POLICIES
RULES AND REGULATIONS

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
Admit inpatients	Attending physician with admitting privileges	Anyone else		Requires a "provisional" diagnosis and tentative plan of care. All podiatry/ dental patients must be co-admitted with physician member of the medical staff.
H&P (non-ICU) handwritten / dictated	Attending, resident, AHP with appropriate privilege Podiatrists for data pertinent to podiatry aspects. Dentists for data pertinent to dental aspects.		Within 24 hours of admission	Includes all pertinent findings resulting from total system assessment. May use one performed within seven (7) days prior to admission, with an interval note written within 24 hours of admission. Must be in chart prior to surgery or procedure will be canceled.
H&P / Admitting Note (ICU)	Attending, resident, AHP with appropriate privilege .		Within 30 minutes of admission	A physician shall evaluate the patient within 30 minutes of admission or just prior to admission with accompanying documentation and initial orders. If attending not within 30 minutes travel time, co-admitter must be designated. Documented evaluation shall be on the chart within four (4) hours.
H&P / Emergency Department	Attending, resident, AHP under standardized procedure	Medical student	Within 24 hours	Documentation shall contain: • Pertinent history of injury/illness and details regarding first aid/emergency care prior to arrival • Description of significant laboratory, clinical and/or roentenologic findings • Diagnosis best explaining reason for care

(*Information in this document is current as of 3/7/04)

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
				• Description of treatment given • Description of patient's condition on discharge or transfer • Final disposition including instructions pertaining to follow-up care • Signature of attending
OB Admitting H&P	Attending, resident	AHP, medical student	Within 24 hours of admission	Legible copy of prenatal record is requested at admission with an interval admission note containing pertinent additions to history and subsequent changes in physical findings.
H&P / Pre-procedure	Attending, resident	AHP, medical student	Within 7 days of surgery for *inpatient* procedures; within 30 days of surgery for *outpatient* procedures	If done prior to 24 hours of surgery, H&P update (pre-procedure evaluation) is required.
Pre-Procedure Evaluation (24 Hour Update)	Attending, resident, AHP	Medical student	Within 24 hours prior to surgery if H&P is older than 24 hours	Must include: • Heart and lung assessment • Condition requiring surgery is still present • Any other significant findings
Progress Notes	Attending resident, AHP	Medical student	Daily	Must reflect any change in condition, the results of treatment and plans for future care. Must reflect attending physician's involvement in patient care. Must be signed by individual producing the note.
Medical Consultation	Attending, resident with attending countersignature	AHP, medical student	Upon time request from attending	Show evidence of patient's record review, pertinent findings on examination, consultant's opinion, recommendations, signature.

(*Information in this document is current as of 3/7/04)

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
				Communication re: urgent or significant unexpected findings should occur directly between physicians.
Order for between services transfer	Attending medical staff member	Non-medical staff member	Upon transfer	Attending must do both ordering and accepting of the transfer.
All clinical entries	All medical staff, allied health professionals, and non-LLUMC-employed AHP with IDP approval	Non-employees/ non-members of the medical staff	As written	Must be accurately dated, timed, and signed.
Operative Report (handwritten / dictated)	Attending, resident	AHP, medical student, anyone who was not present	Immediately after surgery	If operative report is dictated, an operative progress note is entered with pertinent information. Operative report shall include: • Date and time • Name of primary surgeon & assistants • Findings • Technical procedures used • Specimens removed • Postoperative diagnosis
Procedure Note	Someone present at the procedure	Anyone who was not present	Immediately after procedure	Procedure note shall include: • Date and time • Name of primary surgeon & assistants • Findings • Technical procedures used • Specimens removed, if any • Post-procedure condition

(*Information in this document is current as of 3/7/04)

MEDICAL STAFF POLICIES
RULES AND REGULATIONS

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
Orders (written)	Attending, resident, medical student with countersignature, AHP under standardized procedure	AHP without privileges to write orders	When needed	• Must be accurately dated, timed, and signed • Must be written clearly, legibly, and completely. • Orders for diagnostic tests must include appropriate ICD-9 codeable reason. • Orders written by the resident, medical student, and AHP must be signed with beeper number, printed name, and attending name under whom the order is written.
Orders (verbal/ telephone)	Attending, resident, AHP under standardized procedure	AHP without standardized procedure	Only under emergent / urgent conditions	• Must be authenticated within 48 hours, with date and time of signature. • Shall be dictated to registered nurse or student physician. • Orders for respiratory care may be dictated to respiratory care practitioner. • Orders for medications may be dictated to pharmacists. • Orders for dietary needs (except TPN) may be dictated to dietitians.
Orders (authentication of verbal/telephone)	Practitioner who gave the order or is involved in care of patient during this admission	Anyone who has not been involved in care of patient	Within 48 hours in the Medical Center and within 10 days in the Medical Center outpatient areas.	Must include date and time of signature.

(*Information in this document is current as of 3/7/04)

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
Discharge orders	Attending, resident,	AHP, Medical Student	Prior to discharge	
Pronouncement of Death	Licensed physician	All others	Within a reasonable time	Progress note attesting to death shall be dated, timed, and signed by a licensed physician.
Death Certificates	Licensed physician	All others	Within 15 hours of death	Completion specifics: • Use black ink only • Stay within boxes when filling out the form • No errors allowed (e.g., corrections, write-overs, etc.) The form is not required to be typed. Legible handwriting is acceptable. Certificate must be filed with the County no later than 15 hours after death.
Discharge Summaries/Death Summaries (dictated) See limited exception in "Discharge Summaries (Obstetrics)"	Attending, resident, AHP under standardized procedure		Upon discharge, death, patient leaving AMA	Must be signed by attending physician Shall include: • Patient identifying information • Attending physician identifying information • Dates of hospitalization • Reason for admission • Significant findings • Principal diagnosis • Other diagnoses affecting hospitalization • Procedures performed • Description of management of patient's medical problems • Patient's condition at discharge

(*Information in this document is current as of 3/7/04)

ITEM	WHO MAY	WHO MAY NOT	TIME REQUIREMENT	OTHER ISSUES
				• Description of plan for continuing management including instructions to patient and family
Discharge Summaries (Obstetrics)	Attending, resident		Upon discharge	OB patients shall have a dictated discharge summary with the following exception: • normal, spontaneous, vaginal term, non-operative delivery; **AND** • normal infant; **AND** • no obstetrical or medical complications; **AND** • length of stay less than 72 hours
Chart Completion	Attending, resident, AHP All individuals who document in the chart		In a timely manner as determined by Medical Record Committee but not later than 14 days after discharge	All medical staff members are to access EPF at least weekly to complete all available records. Prior to any absence of greater than five (5) days or longer from LLUMC, all available records are to be completed. Extended absences require notification of Health Information Management Department of the planned absence and expected date of return.
Suspension Policy	Attending			> 10 inpatient records, older than 28 days or any <u>one</u> operative report older than 24 hours will lead to suspension. Fee will be assessed for each suspension in order to reactivate medical staff membership, as follows, $100 for first suspension, $200 for second, $400 for third, etc.
Suspension Policy	Resident			As defined by Graduate Medical Education Committee.

(*Information in this document is current as of 3/7/04)

TEACHING AND EVALUATING MEDICAL STUDENTS

By Leonard S. Werner, MD

Housestaff play a critical role in medical student teaching and evaluation. The instruction received from housestaff is a significant part of medical student education. While some of this instruction occurs through formal presentations, most occurs through informal modeling and the constant exposure that students have to residents. As adult learners, medical students learn best when they: a) apply what they have learned soon after they have learned it; b) apply problem solving to understanding concepts and principles; c) play an active role in their own education; and d) receive timely feedback regarding their own performance.

Medical students have come through a system of education that relies heavily on lecture. This form of education is teacher-active but learner-passive. During their clinical education, medical students must make a difficult transition. Teaching rounds replace the lecture as the chief mode of education. Teaching rounds are commonly teacher-passive but learner-active. For teaching rounds to be effective, they should take place temporally and physically separate from work rounds. Open-ended questions requiring more than a single answer should be used as a primary mode of teaching. Students should be encouraged to analyze, defend, interpret or justify, not just recall, list or recite. “Pimping” is not an effective teaching method. Clinical problem solving and decision making should be a high priority. Since teaching rounds are not lectures, no single individual (resident or student) should dominate the discussions.

Whenever possible, some time should be set aside for bedside teaching where modeling can take place. Bedside teaching provides the opportunity for residents and students to be active teachers and learners respectively. The bedside is the only place where interviewing, physical examination and psychomotor skills can be adequately taught and evaluated. When teaching at the bedside, the knowledge, skills, values, and attitudes being discussed should always relate to the patient. The patient’s comfort and dignity must always be respected. Skills must be taught taking into consideration the comfort level of the student. Since many students do not know what they do not know, it is important to teach skills in a stepwise manner. Housestaff should be understanding, patient, and supportive of students as they learn new skills. Timely feedback is again critical for reinforcing learning and ways to improve the future.

Feedback is crucial for the student’s growth and is most effective when it is given in a timely manner, in a climate of trust and mutual respect. Regular feedback is more effective than sporadic feedback. Feedback should begin with positive observations and occur in a confidential setting where privacy is assured. Inviting the learner’s self-critique is a good place to start. Whenever possible, link the feedback that you give to the learner’s own self-identified goals. Feedback should relate to direct observations and should be as specific as possible. To be maximally effective, language should be non-threatening and non-judgmental. Provide the learners with objective evidence and focus on the observed behaviors and performances whenever possible. Do not overload learners with feedback. In the early stages of their careers, most learners can only handle one or two issues at a time. Always leave learners with a few achievable goals and follow-up steps that they can accomplish. Avoid directing feedback toward those things that the learner is unlikely to be able to change. Encourage learners to give constructive feedback to each other.

Before the feedback session ends, be sure that the learner is comfortable with the process that has taken place.

Name:		**Date:**	
Mailing Address:		**Specialty:**	
		Phone:	
		Fax:	

P.U.R.P.L.E BOOK TEST QUESTIONS for MODERATE SEDATION

The Study Guide is provided for those physicians eligible to apply for **Moderate Sedation** privileges. The Study Guide is approximately 74 pages, so you may consider printing only the Test and reviewing the Study Guide on-line.

Once you have **completed the test**, please **fax** it **to Medical Staff Administration** at 909/558-6053 (x 66053). Your test will be graded and a certificate faxed to those passing the test. Please be sure to complete all the information at the top of this test.

1.	T	F	An advance directive is a physician's wishes for individual patient care.
2.	T	F	Ethicists are on call for consultation.
3.	T	F	A limitation of treatment order is a physician's order generated by and signed by a licensed physician only.
4.	T	F	A Living Will is <u>not</u> a form of an advance directive.
5.	T	F	An autopsy plays an important role in completing the circle of medical care.
6.	T	F	Teaching physicians are to use the personal pronoun "I" to describe in the medical record the services they personally provided to the patient.
7.	T	F	Non-covered Medicare services such as routine screening, annual health exams, etc. may not generally be billed to the Medicare program.
8.	T	F	If the teaching physician merely countersigns the resident's notes without recording his/her presence or re-performance of the history and physical, the teaching physician shall not fill out any charge capture form for billing purposes.
9.	T	F	The medical record must accurately reflect the actual involvement of the teaching physician in the care and treatment of the patient.
10.	T	F	EPF stands for electronic patient folder.
11.	T	F	With EPF, chart completion can be handled via computer.
12.	T	F	Orders for diagnostic testing must contain an ICD-9 codeable reason before the order will be implemented.
13.	T	F	Signatures on orders must contain the resident's signature, beeper number, and name of attending physician under whose direction the order is written.
14.	T	F	You must never turn away a <u>legitimate</u> request for a higher level of care for a patient.
15.	T	F	EMTALA is colloquially known as the "Cobra Law."

Name:		**Date:**	
Mailing Address:		**Specialty:**	
		Phone:	
		Fax:	

P.U.R.P.L.E BOOK TEST QUESTIONS for MODERATE SEDATION

16.	T	F	The Medical Center imposes confidentiality restrictions on all victims of violent crimes.
17.	T	F	It is appropriate for employees to discuss patient information in the cafeteria and on elevators.
18.	T	F	Medical staff members should never sign off the computer when they have finished working confidential information.
19.	T	F	Medical staff members should never allow others to use their personal computer passwords.
20.	T	F	Information security and confidentiality must be maintained in every department and unit throughout the Medical Center and its facilities.
21.	T	F	HIPAA's privacy rule protects only patient information in electronic form.
22.	T	F	For individuals who knowingly misuse a patient's health information under false pretenses, the penalty is fines up to $100,000 and/or imprisonment for a term up to five (5) years.
23.	T	F	There are new state and federal laws related to confidentiality of medical information.
24.	T	F	Failure to follow the laws on confidentiality will result in penalties of up to $250,000 and/or imprisonment up to 10 years.
25.	T	F	Physicians are exempt from the state and federal laws on confidentiality of medical information.
26.	T	F	It is the physician's duty to provide information on the proposed procedure/treatment with its accompanying risks and benefits plus the alternatives to the procedure/treatment.
27.	T	F	The informed consent process does not have to be documented in the medical record.
28.	T	F	No procedures can ever be done without consent from the patient.
29.	T	F	The Paul Gann Blood Safety Act refers to informing the patient regarding the risks and benefits of blood transfusions.
30.	T	F	Patients have the right to know who their healthcare provider is, e.g., nurses, physicians.
31.	T	F	Hospitals are required to give patients a list of their rights.
32.	T	F	Patients have the right to receive information regarding their care/treatment in terms they understand.

Name: _____ **Date:** _____

Specialty: _____

P.U.R.P.L.E BOOK TEST QUESTIONS

33.	T	F	The recipient of sexual harassment does not have to be of the opposite sex from the offender.
34.	T	F	A hostile working environment can be the result of dirty joke-telling or hearing others talk about their personal love relationship.
35.	T	F	Medical staff members are not required to follow the sexual harassment policies.
36.	T	F	A pre-sedation assessment must include an acknowledgement of informed consent.
37.	T	F	Moderate sedation has been achieved when a sedated patient is unresponsive to all painful stimuli
38.	T	F	A pre-sedation assessment may be performed any time within a week of the planned procedure.
39.	T	F	After drinking a glass of water, all patients must wait 4 hours before undergoing procedure related sedation
40.	T	F	An intravenous line must be placed for all patients undergoing moderate sedation.
41.	T	F	Vital signs must be documented every 15 minutes during moderate sedation.
42.	T	F	Complications and the management of the complications must be documented in the medical record.
43.	T	F	All patients must be observed for 60 minutes following the completion of the procedure before being discharged home.
44.	T	F	PRN orders for restraints may be written if the physician is in a hurry.
45.	T	F	Verbal/telephone orders are to be authenticated with date, time, and signature.
46.	T	F	Medical staff are required to report identified cases of unusual diseases or conditions to the local health officer.
47.	T	F	The Medical Center has moved from quality assurance to performance improvement.
48.	T	F	For feedback to be most effective in modifying behavior, it should be timely.
49.	T	F	Active teaching and learning most commonly occur together during faculty lectures.
50.	T	F	Adult learners learn best when they play an active role in their own education.

Fraud and Abuse Test

Name: **ID #:**

Date:

Department:

1. If providers fail to correct mistakes and return overpaid monies, they may be suspected of fraud.
   a. Yes
   b. No

2. Which governmental entity is primarily responsible for Medicare fraud investigations?
   a. OIG
   b. FBI
   c. IRS

3. What safe guards should providers have in place when treating Medicare beneficiaries?
   a. Recognize what services Medicare covers.
   b. Ensure patients should only receive services that are medically necessary and reasonable for their condition.
   c. Follow Medicare guidelines and procedures.
   d. All of the above.
   e. None of the above.

4. Identify the following situations as either Fraud (F) or Abuse (A).
   a. ___ Billing for services not rendered.
   b. ___ **Routinely** submitting duplicate claims.
   c. ___ Upcoding on a consistent basis.
   d. ___ Offering incentives only to Medicare patients.
   e. ___ Billing for services in excess of what the patient needs.

5. Is a provider responsible for following published information even if they don't see the publication?
   a. Yes
   b. No

6. Can a provider be fined, excluded from the Medicare program, or imprisoned for errors made by their staff?
   a. Yes
   b. No

7. Is the patient financially responsible for payment of non-covered services they receive?
   a. Yes
   b. No

8. Fraud and abuse cases are committed most often by patients.
   a. True
   b. False

9. The Anti-Kickback Statute prohibits:
   a. Soliciting or receiving remuneration for referrals of Medicare or Medi-Cal patients.
   b. Offering or paying remuneration for referrals of Medicare or Medi-Cal patients.
   c. All of the above.
   d. None of the above.

10. An Advance Beneficiary Notice (ABN) is required for services that may be considered medically unnecessary.
    a. True
    b. False