

Section: Division of Nursing  
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**PROCEDURE**  
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HACKETTSTOWN REGIONAL MEDICAL CENTER

Reviewed By: D. Oleksy, ED, US

ED  
(Scope)

**TITLE: EMERGENCY DEPARTMENT BILLING PROCEDURE**

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**PURPOSE:** To delineate the ED secretarial process for billing patients who visit the ED.

**SUPPORTIVE DATA:** The patient's bill must be generated in an accurate and timely manner. The information for preparing the patient's bill for ED treatment is documented at the point of service. The ED Patient Charge Form is entered via computer by the ED secretary using documentation supplied by nurses and physicians.

**EQUIPMENT LIST:**

1. Patient's chart
2. Emergency Room Charges - Supply and Equipment List
3. Pen – Mark all charges in red
4. Computer System

<b>CONTENT:</b>	<b><u>PROCEDURE STEPS:</u></b>	<b><u>KEY POINTS:</u></b>
	<ol style="list-style-type: none"><li>1. Gather charts from previous day.</li></ol>	<p>Patient charts to be logged, copied and separated. Charts may be billed out as soon as treatment and documentation is completed or *3-4 day window for charges to be entered into the computer system.</p>
	<ol style="list-style-type: none"><li>2. Check charts against ED log to ascertain there is a chart for every patient logged in.</li></ol>	<p>Using patient charts, Medical Record originals and ED patient chart copies, a penciled checkmark is placed next to patient name in black logbook.</p> <p>Track down any missing charts. Possible locations:</p> <ol style="list-style-type: none"><li>a. Doctor's file (for completion)</li><li>b. Nurses file (for completion)</li><li>c. Sent to inpatient unit by mistake</li></ol>
	<ol style="list-style-type: none"><li>3. Patient Charges<ol style="list-style-type: none"><li>a. Nurse marks appropriate item/equipment charges</li></ol></li></ol>	<p>ED Secretary has to check and or enter charges Find patient in computer system Discharge patient as necessary Go to patient menu click #5 patient inquiry.</p>
	<ol style="list-style-type: none"><li>b. Check with HCH ED patient Charge Sheet that all charges are in computer system.</li></ol>	<p>Use a red pen and check each item on charge sheet and initial the charge sheet. Charges are not in computer system, ED Secretary has to enter charges (mark x or v in red pen each item).</p>
	<ol style="list-style-type: none"><li>c. Charges needing to be edited or deleted.</li></ol>	<p>Flag patient charges with a note stating changes or if any questions on charges for ED Secretary Coordinator to edit</p>
	<ol style="list-style-type: none"><li>d. Give all ED patient chart copies to the ED Secretary Coordinator or place on shelf marked "Patient Charts to be Charged Out in System."</li></ol>	<p>All secretaries or techs are to enter charges. Edits of charges are left for Unit Secretary or Unit Coordinator. When entering charges please remember all charges need to be entered for same day or within 3-4 days of visit. Patient <b>entered</b> the ED (came in on 10/1/00 at 10pm</p>

and the discharged from the ED or admitted to the unit on 10/2/00 at 3 am. When charging the patient the **date should be changed T-1 or 10/01/00. Add five minutes to time on ED patient chart. (i.e. 22:05 – 22:10)**

\*Charts "Present Day" Logging process.

4. Logging Patient Demographics (left side of logbook before treatment begins)
  - a. **Date** left top of page or beginning a new date
  - b. **Account** number (below date) then time
  - c. **Name of Patient**, Last name, first name, patient home telephone number, if non try a relative, if none try work number.
  - d. **Age and Sex**
  - e. **Nurse Name** column – 3 columns, **Triage, Attending, Other** fill in this column at the end of patient treatment.
  - f. **The ED Physician Name.** The physician column is to have a **black line down the middle of the physician column.** When more than one ED Physician is on, log this column after patient is treated. See logging right side of log book
  - g. **PMD** – patient medical doctor (family)
  - h. **GPOP** – Patient medical private MD. Stamp logbook with stamper under attending physician. (Write name of patient medical private physician).
  - i. **Arrived by** i.e., car/SQ
5. Logging Patient Demographics (right side of logbook after treatment ends)
  - a. Arrived by car/ambulance i.e., sq/Long Valley
  - b. Diagnosis
  - c. Write name of ancillary department of ordered tests (i.e., lab, EKG, X-ray)
  - d. Document if **tetanus** was given (rabies shot 1, 2 or 3).
  - e. Treated & discharged place (√) mark when treated and discharged when LWS no (√) mark is to be entered.
  - f. Discharge time or if patient admitted to floor write room number, name of admitting physician, time patient went to floor.
  - g. Stamp **Admit, GPOP, SDS** or **TRANSFER** with hospital name, **EXPIRED**, or patient leaving **AMA** or **LWS** (against medical advice, left without seen).
6. Patient Chart, **Check for Completion**
  - a. Physician signature on face sheet orders or medication listed.
  - b. Physicians' signature on Physician's note page(s)
  - c. History, physical and plan on physician

**This should be done before copy process.**

- note page.
  - d. Diagnosis or impression on Physician note page
  - e. Physician to mark condition at discharge.
    - a. Stable
    - b. Improved
    - c. Guarded
  - f. Assessment page, nursing note page
  - g. Nurses' signature on nursing notes, triage sheet and face sheet of patient chart.
7. Patient chart, **Not Completed**
- a. Place patient original chart in respective physician folder located in the file cabinet by physician station. Write "Dr" next to patient's name in black logbook.
  - b. When a chart is missing nursing documentation separate physician billing copy of patient chart and place in physician billing bin or Office Manager drawer.
  - c. Remainder of patient chart is to go in the middle black bin located near the ED Secretary for nurses to pull and complete documentation.
  - d. Next to patient's name in black logbook, write **middle bin** = represent the Nurse to complete Triage/Nursing Notes.
  - e. All admission charts to be reviewed by Nurse Coordinator/Charge before copying and or originals leaving the ED Department.
8. Patient Chart **Copying Process** (i.e. face sheet, triage sheet)
- a. Patient's charts are to be kept in time order (00:00 – 23:59)
  - b. Copy patient face sheet x 3
  - c. Copy front of triage sheet x 1
  - d. Copy nursing notes x 1
  - e. **Exceptions:** Employee related or workers compensation – face sheet 4x, physician note page, front of triage sheet x 2, nursing notes x 2, incident report x 3 and consent blood draw x2.
9. Patient Chart , **Separation Process**
- a. ED Patient Chart Copy
    - 1. Copy of patient face sheet
    - 2. Copy of physician note page
    - 3. Copy of front triage sheet
    - 4. Copy of nursing note page
    - 5. Copy of HCH ED charge sheet
  - b. Physician's billing chart copy
    - 1. Copy of patient face sheet
    - 2. Copy of physician note page
    - 3. Copy of patient insurance information
    - 4. Make sure physician signature and patient name is visible on copies. (Physicians will not get paid of billing company cannot read or obtain the right information).
  - c. Medical Record Original Patient chart
    - 1. Original patient face sheet

Staple steps 1 through 5 (or 1 through 6) and place in the black bin labeled **ED Charts**. After Medical Record originals have been all accounted for and check marked by patient name, using Ed chart copy mark in a check mark to account for all ED patient charts for the same day of visit

Staple steps 1 through 5 (or 1 through 6) and place in black bin labeled **Physician Billing**.

2. Original physician note page
  3. Original triage sheet
  4. Original ancillary tests results form (i.e., Lab, EKG).
  5. **Exceptions:** Copy of HCH Employee incident report and a copy of request Alcohol and Drug Screening signature form.
- Staple steps 1 through 4, (or 1 through 5) and place in black bin labeled **Medical Record Copy**
- d. HCH Employee Health Copy – HCH Workers Compensation
    1. Copy of patient face sheet
    2. Copy of physician note page
    3. Copy of front triage sheet
    4. Copy of nursing notes
    5. Employee Health **original** HIV, blood consent form.
    6. Employee **original** incident report.
- Staple steps 1 through 6, place in **folder** labeled **Employee Health** located in Registration File Cabinet.
10. Black logbook – Documentation (log in, right and left side) – check for completion of documentation.
  11. Pediatric (black) log book to be updated and checked for completion of chart documentation (right and left side, logging of patient chart information)
  12. Patient Chart Distribution Process
    - a. ED copy of patient charts. To check charges.
    - b. Physician billing patient chart.
    - c. Medical Staff patient copies
    - d. Medical records original patient chart.
- To check charges. Placed on the Ed Coordinator's desk for entering charge in computer.  
Placed in physician billing filing cabinet.  
Place on top of medical record cabinet.  
They are given to Nurse Coordinator or Charge Nurse for chart review. Once completed by secretary, charts are placed in Medical Record Cabinet.

REFERENCE: