ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TEACHING HOSPITAL MEDICAL STAFF ORGANIZATION

PRINCIPLES FOR REIMBURSEMENT

PMM & Co. Peat, Marwick, Mitchell & Co. April 1970

ASSOCIATION OF
MEDICAL COLLEGES

TEACHING HOSPITAL
MEDICAL STAFF ORGANIZATION

PRINCIPLES
FOR REIMBURSEMENT

PREPARED BY

PEAT, MARWICK, MITCHELL & CO.
1025 CONNECTICUT AVE., N.W.
WASHINGTON, D.C. 20036

MAY 6, 1970

PEAT, MARWICK, MITCHELL & CO.
1025 CONNECTICUT AVE., N. W.
WASHINGTON, D. C. 20036

May 6, 1970

Mr. John M. Danielson
The Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle
Washington, D.C.

Dear Mr. Danielson:

Peat, Marwick, Mitchell & Co. is submitting this final report which will complete the contractual requirements of our engagement with the Association of American Medical Colleges, relating to the payment of professional services rendered in teaching hospitals under Public Law 89-97. The final report contains a Preamble and a Statement of Principles for the AAMC. Appended to this document are teaching hospital staff organization patterns and hospital objectives and approaches to expenses and revenues.

The engagement approach was to utilize Peat, Marwick, Mitchell & Co. consultants, in conjunction with AAMC personnel, who have experience with teaching hospitals and the administration of P.L. 89-97. Preliminary documents were submitted to an advisory committee following which recommended changes were made. For determining the medical staff organization, PMM&Co. developed a matrix and visited six teaching hospital settings to test its viability.

It is our understanding that the Statement of Principles will be further reviewed by AAMC officials.

Mr. John M. Danielson
The Council of Teaching Hospitals

May 6, 1970
-2-

Because of the importance of the nation's teaching hospitals in providing the setting for services to patients, clinical education,and research, may we take this opportunity to compliment the AAMC for the leadership it has demonstrated in postulating these principles.

Sincerely,

PEAT, MARWICK, MITCHELL & CO.

Philip L. O'Connell
Principal

TABLE OF CONTENTS

I. BACKGROUND

The second half of the twentieth century has brought the controversies of progress to the American medical scene. The public is generally aware of the giant strides that American medical knowledge has made in relieving many aspects of human suffering. As a result, the demand for medical services has risen sharply which, in turn, has created some serious problems, including how to:

- prepare more and better educated medical professional personnel;
- improve the use of available financial, personnel, and facility resources;
- develop a better system for the delivery of health and medical care;
- make high quality health and medical care available to everyone;
- provide programs and services to all at a price they can afford to pay.

The controversies that arise, relating to these problems are:

- determining the degree of government involvement in health and medical affairs;
- developing leadership for solution of problems in the health care field;
- establishing closer working relationships between doctors and hospitals for dealing with health and medical care problems in the community;
- developing a master plan to guide the implementation of innovative programs for controlling resources while providing

services to patients, education of medical personnel, research in medical sciences, management systems of health affairs, and information systems for evaluating current and future program effectiveness; and

. determining the objectives for a health care system and the roles of practitioners and institutions in their communities.

The Senate Finance Committee recently prepared a report which confronted the teaching hospitals and the schools of medicine with these problems and controversies. The report, in part, centers upon the payment for services rendered by the medical staff of a teaching hospital under Public Law 89-97. It indicates that, in some instances, the manner in which the medical staff is organized to provide patient care does not comply with the requirements for payment. There are professional health and medical services rendered for patients in teaching hospitals which, under any rule of equity, should be eligible for payment. The question is whether the medical staff is organized, as pertains to P.L. 89-97, in a manner that makes it eligible to receive payment for those services rendered.

It should be pointed out that patients have the right of choosing a physician to personally provide their care under this law. Further, they have the right, under the law, to choose the institution and method whereby this professional service is rendered. Whether the services in a setting are or should be personally provided, is part of the controversy. It also should be noted that clinical education of students, interns, and residents is involved in this consideration. Further, the financial solvency of the hospital in obtaining revenue for its operation from these services is a major concern.

Thus the membership of the Association of American Medical Colleges (AAMC) has much at stake in the satisfactory resolution of these problems. AAMC leadership, therefore, is essential to any consideration of:

- altering the organization of the medical staff of the teaching hospital;

- altering the existing administrative regulations of P.L. 89-97; and

- amending the law itself.

First, the AAMC must take a general policy position affecting the medical staff organization of teaching hospitals. Second, the AAMC staff must speak for its member hospitals in working out solutions to problems related to P.L. 89-97 with governmental officials. On the one hand, AAMC must consider the financial requirements of the hospital and its medical staff. On the other hand, its policies should not restrict the opportunities of a teaching hospital to consider alternative methods of staff organization to deliver services, nor should they interfere with the development of innovative educational relationships of the medical staff with students, interns, and residents. Accordingly, the principles set forth in this report are, in effect, standards upon which AAMC members can seek agreement and which may alleviate the problems which governmental officials face in administering P.L. 89-97 including payment for services rendered.

The member institutions of the AAMC should recognize that the parent organization must establish a policy that sets forth alternative ways in which a medical staff may be organized to provide patient services in a teaching setting while complying with the requirements of P.L. 89-97. In addition, the AAMC should assume a leadership role in improving the nation's health and medical system. An action-oriented program for comprehensive health planning in each region served by a teaching hospital appears essential in view of the national crisis in the delivery of health services.

During the engagement, Peat, Marwick, Mitchell & Co. worked closely with the AAMC staff in developing background materials for a Statement of Principles that would be used as a guide for the organization of medical staffs of teaching hospitals. To support the discussion of the advisory committee appointed by the President of the AAMC, additional

documents were developed to illustrate several of the approaches that AAMC could consider in determining principles. The first of these documents is a categorization of existing patterns of teaching hospital staff organization and hospital governing control, and appears in this report as Appendix A. In the second document, Appendix B, broad objectives for a teaching hospital are presented, and approaches to the isolation of hospital and professional expenses and revenues are developed. The purpose of this document is to initiate discussions about the flow of money in the hospital as it provides services and education and research programs.

To illustrate when payment may be made for professional services performed by the medical staff and the associated staff, we have prepared a matrix and included it as Appendix C.

Section II presents the Statement of Principles. These principles were reviewed and rewritten as a result of staff conferences and the advisory committee meeting. Incorporated in the Statement of Principles is a definition of terms and a Preamble which states the issues to which the principles are directed.

Since PMM&Co. has an active interest in and concern for the nation's health care programs, it has been a distinct pleasure to work with the AAMC on this project, and we offer our continued interest and service as it may be needed in the future.

II. STATEMENT OF PRINCIPLES

Preamble

The Association of American Medical Colleges' (AAMC) Statement of Principles is structured upon Section 1892 of P.L. 89-97, wherein it is stated:

> Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

AAMC believes this guarantee of freedom of choice and acceptance should be extended to all patients in the nation.

Teaching hospitals have a special role and responsibility in the delivery of health care and the education and training of health professionals. The nation looks to them for excellence in the provision of care. Teaching hospitals are expected to provide highly skilled personnel and a broad spectrum of programs and services, education, and research. They provide the setting for the major part of the education and training of the nation's physicians and other health professionals. These obligations place an unusually heavy financial burden upon the teaching hospital.

The patient turns to the teaching hospital for a high level of health and medical services, which are unusually complex, scientifically advanced, and costly in nature, to meet his special needs. In meeting these needs, the hospital and the physician are ultimately legally and morally responsible for the quality of care which the patient receives; and to provide for this care, the hospital must maintain a qualified medical staff. In the teaching hospital, this medical staff may be organized in a variety of ways to encompass its responsibilities for services to patients, education, and research.

The availability of patients through the practice of medicine by the medical staff is essential to the education of health personnel and is important to the development of health manpower. In addition, the practice of the teaching staff is important to the community because teaching physicians are in the forefront of the knowledge of medical sciences.

Statement of Principles*

These principles are written to clarify the organizational relationships in the teaching hospital. They define certain necessary financial relationships of the hospital, its medical staff and associated staff, to assist and support them in their educational as well as patient care activities.

1. In any legislation dealing with health care, it is essential that research and development, innovation, and demonstration of new methods for the delivery of health care services be promoted. At the same time, it is important to experiment with and evaluate new methods of payment for such services.

   In developing alternative methods of organizing the teaching hospital medical staff along different delivery patterns, payment for hospital and professional services should be commensurate with the effort incurred in the rendering of that service. For example, ways could be designed to render "units of service" and payment made for these "units of service" based on reasonable charges. The hospital and its medical staff should be supported in developing ways to extend the quantity, quality, and equality of health care to all socio-economic levels of society.

---

*It is to be emphasized that these principles relate to the teaching hospital and its medical staff and not to the medical school itself, except as the medical school faculty participates in the delivery of medical care.

2. Every patient admitted to the hospital has the right to the personal services of a responsible physician on the hospital medical staff, in charge of his diagnosis and therapy.

The Association of American Medical Colleges concurs that this is necessary to insure the highest quality of care possible for the patient. It is also necessary for establishing responsibility for the management of the care and for payment of professional fees. This patient-physician relationship should also exist because of medical-legal problems which extend from out-patient, emergency, and continuing hospital medical care. Further, it is necessary for the conduct of medical education, which increasingly will involve the private patient-medical staff relationship.

3. The teaching hospital's medical staff should be organized as a team to provide continuous, direct, and personal care to patients and should develop organizational methods which guarantee appropriate access for patients, as well as availability of on-call and emergency services.

Every patient has the freedom to choose the arrangements under which he will receive medical care. Included is the right to all of the advantages which accompany a close relationship between the responsible physician and his associated staff in education as well as practice.

4. A charge should be made for all hospital and professional services rendered to patients.

Improvements in the payment for medical services, while still not adequate, have affected the relationships among patient, doctor, hospital, and the payor. Since there are increasingly fewer individuals without some form of health insurance, this change in relationships requires development of a greater

understanding between hospital and medical staff organizations relative to hospital costs and professional charges. The payors must also recognize the implications of inadequate reimbursement for patient care in the teaching setting.

5. Any member of the hospital medical staff rendering professional services to the patient is eligible for payment for such services. The medical staff and associate staff should be organized for rendering services to patients in a manner which will allow accountability for charges submitted. The senior resident and/or chief resident may be considered eligible for appointment to the medical staff with appropriate limitations on his privileges.

   Since the medical staff of the teaching hospital is departmentalized and the associated staff is assigned along these departmental lines, all physicians restrict their practices to a greater or lesser degree. It follows that the senior resident and/or chief resident can accept responsibility for the medical care of patients within limits set by the senior medical staff members who are responsible for the conduct of his education, training, and experience. Senior and chief residents may be assigned responsibilities similar to those of the attending physician personally assisting interns and other residents with the care of patients. They may render consultations.

6. As an acceptance of public accountability, the teaching hospitals and medical staff agree that a professional audit of patient records and other pertinent documents should be continued and that documentation describing professional services rendered be incorporated into the patient's medical record.

7. <u>The teaching hospital must have adequate financial resources for current operations, new and/or expanded programs as well as capital uses</u>.

The teaching hospital's expansion of scientific competence is in direct response to the growth of the body of medical knowledge. This growth imposes new requirements for space, equipment, and personnel to bring to patients the best in modern medical care.

The special nature of the teaching hospitals in their capacity of providing high quality, frequently innovative medical care, in providing an environment for teaching and scientific research, and in setting standards of excellence, have caused the costs of providing care in these hospitals to rise. As the hospitals attempt to meet the increase in public demand for services, and as they meet expanding modern scientific standards, requiring more highly skilled personnel, this trend is expected to continue. At the same time, however, teaching hospitals have a special obligation to improve the management of patient care, to maximize the use of available resources, and to minimize the patient's length of stay.

The teaching hospital is the environment in which medical scientific knowledge and skills are translated into innovations in methods and equipment for the delivery of high quality medical care. Growing specialization in medicine requires greater coordination of patient care management to avoid undue fractionation. However, new or expanded programs or services should be related to the demonstration of need.

Definition of Terms

1. Personally Rendered Professional Services

In the teaching hospital, the quality of care rendered to all patients should not be determined by economic status or the method of entry into the health care system. Each has a responsible physician who personally rendered care.

The responsible physician may utilize the professional services of the associated staff or other staff members, creating a team-of-physicians approach to patient care. To qualify for billing and collecting the professional fees for such services, there should be evidence that the responsible physician has personally rendered the care having reviewed and coordinated all care rendered by the team. Further, during technical procedures, such as surgical operations, the responsible physician must be present even though he may not be the operating surgeon of record. This means that the patient is informed of the team members. It is understood that, as a member of the team, the responsible physician may only observe the procedure, being immediately available to perform the surgery if needed.

"Personally rendered professional services" also includes those services provided by a member of the hospital medical staff, at the request of the patient's responsible physician, and with the patient's knowledge. It is necessary that an opportunity be provided to make a unit charge for the total service rendered in the diagnosis, treatment and follow-up of an episode of disease. In the teaching hospital, the unit of service involves the medical care team and the reimbursement should be negotiated to cover appropriate charges for the care rendered.

2. Medical Staff Patient

A patient who has chosen a member of the hospital's medical staff, or has accepted a practicing physician

assigned by the medical staff of the hospital to personally provide and be responsible for his medical care. Assignment of a physician is accomplished in accordance with established policies and procedures agreed upon by the medical staff and the hospital.

3. Attending Physician

A physician who has been appointed by the hospital to the hospital's medical staff, to personally provide and be responsible for the care of the patients.

4. Responsible Physician

A physician who has been appointed to the hospital's medical staff who assumes the responsibility for providing or observing personally the medical care of his patients. The responsible physician may be a faculty member, a chief resident, senior resident or any other member of the medical staff.

5. Eligible

Professional fees may be billed for services rendered by the medical staff. Professional fees may be billed for services rendered by the associated staff when a responsible physician is personally present.

6. Associated Staff

The interns, assistant residents, residents, senior residents and chief resident physicians who are appointed to the hospital's approved teaching programs by the medical school faculty, the hospital's medical staff and the hospital.

7. Assistant Resident

A physician who has been appointed to the hospital's graduate education staff but has not yet attained the final year or two years of specialty qualifications (as described in #8 below).

8. Resident

A physician who has been appointed to the hospital's graduate education staff and has attained:

a. Final year of a two- or three-year program, or

b. The final two years of a four-year or longer program.

9. Senior Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He may be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. He has the training chronology of the chief resident on the specialty service, but does not have that designation.

10. Chief Resident

A resident physician who has been appointed to a hospital's graduate education staff and has attained the final year of Board required training, or beyond. He can be appointed to the hospital's active medical staff for an appropriate period according to the policy of the hospital. The designation of chief resident and the selection of the chief resident is a function of the medical school faculty, the hospital's medical staff, and the hospital.

11. Medical Care Team

As referred to in these principles and accompanying documents, the team consists of a responsible physician from the hospital's medical staff working with one or more members of the associated staff. The team in special care situations may also include other members of the hospital's medical staff working with the responsible physician and members of the associated staff.

APPENDICES

APPENDIX A

Principal Medical Staff Organization Patterns

Pattern I

I. Hospital medical staff

A. Composition

. Clinical faculty of the medical school only

B. Payment

. Salaried by the medical school

II. Hospital associated medical staff

A. Payment alternatives

. Salaried by the medical school

. Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

. Private, non-profit

. Government - state, county, local

Pattern II

I. Hospital medical staff

A. Composition

. Clinical faculty of the medical school only

B. Payment

. Partially salaried by the medical school

. Partial fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

. Salaried by the medical school

. Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

. Private, non-profit

. Government - state, county, local

Pattern III

I. Hospital medical staff

A. Composition

. Clinical faculty of the medical school

. Attending staff with medical school appointment

B. Payment alternatives

. Clinical faculty - salaried by the medical school

. Clinical faculty - partially salaried by the medical school

- Clinical faculty - partial fee-for-service arrangement
- Attending staff - salaried by the medical school
- Attending staff - partially salaried by medical school
- Attending staff - partial fee-for-service arrangement

II. Hospital associated medical staff

A. Payment Alternatives

- Salaried by the medical school
- Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- Private, non-profit
- Government - state, county, local

Pattern IV

I. Hospital medical staff

A. Composition

- Clinical faculty of the medical school
- Attending staff with medical school appointment
- Attending staff without medical school appointment

B. Payment alternatives

- Clinical faculty - salaried by the medical school
- Clinical faculty - partially salaried by the medical school
- Clinical faculty - partial fee-for-service arrangement
- Attending staff with medical school appointment - salaried by the medical school
- Attending staff with medical school appointment - fee-for-service arrangement
- Attending staff without medical school appointment - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- Salaried by the medical school
- Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- Private, non-profit
- Government - state, county, local

Pattern V

I. Hospital medical staff

A. Composition

- Clinical faculty of the medical school
- Attending staff without medical school appointment

B. Payment alternatives

- Clinical faculty - salaried by the medical school
- Clinical faculty - partially salaried by the medical school
- Clinical faculty - partial fee-for-service arrangement
- Attending staff - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

- Salaried by the medical school
- Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by university

B. Owned by another organization

- Private, non-profit
- Government - state, county, local

Pattern VI

I. Hospital medical staff

A. Composition

- Clinical faculty of the medical school
- Hospital appointed full-time or part-time staff

B. Payment alternatives

- Clinical faculty - salaried by the medical school
- Clinical faculty - partially salaried by the medical school
- Clinical faculty - partial fee-for-service arrangement
- Hospital staff - salaried by the hospital
- Hospital staff - partially salaried by the hospital
- Hospital staff - partial fee for service arrangement
- Hospital staff - percentage of revenue

II. Hospital associated medical staff

A. Payment alternatives

- Salaried by the medical school
- Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by the university

B. Owned by another organization

- Private, non-profit
- Government - state, county, local

Pattern VII

I. Hospital medical staff

A. Composition

- Clinical faculty of the medical school
- Hospital appointed full-time or part-time staff
- Attending staff without medical school appointment

B. Payment alternatives

- Clinical faculty - salaried by the medical school
- Clinical faculty - partially salaried by the medical school
- Clinical faculty - partial fee-for-service arrangement
- Hospital staff - salaried by the hospital
- Hospital staff - partially salaried by the hospital
- Hospital staff - partial fee-for-service arrangement
- Hospital staff - percentage of revenue
- Attending staff - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment alternatives

. Salaried by the medical school

. Salaried by the hospital

III. Hospital ownership alternatives

A. Owned by the university

B. Owned by another organization

. Private, non-profit

. Government - state, county, local

Pattern VIII

I. Hospital medical staff - non-university

A. Composition

. Attending staff of neighboring medical school

. Attending staff without medical school appointment

B. Payment

. Fee-for-service arrangement

II. Hospital associated medical staff

A. Payment

. Salaried by the hospital

III. Hospital ownership alternatives

A. Private, non-profit

B. Government - state, county, local

Pattern IX

I. Hospital medical staff - non-university

A. Composition

. Full-time hospital staff

B. Payment

. Salaried by the hospital

II. Hospital associated medical staff

. Salaried by the hospital

III. Hospital ownership

. Private, non-profit

Pattern X

I. Hospital medical staff - non-university

A. Composition

. Hospital full-time chiefs of staff

. Attending staff

B. Payment alternatives

. Hospital full-time chiefs - salaried by the hospital

- Hospital full-time chiefs - percentage of revenue
- Attending staff - fee-for-service arrangement

II. Hospital associated medical staff

A. Payment

- Salaried by the hospital

III. Hospital ownership

A. Private, non-profit

B. Government - state, county, local

Pattern XI

I. Hospital medical staff - non-university

A. Composition

- Attending staff

B. Payment

- Fee for service

II. Hospital associated medical staff

A. Payment

- Salaried by the hospital

III. Hospital ownership

A. Private, non-profit

APPENDIX B

Teaching Hospital Organization

Assumptions Regarding Hospital Objectives

1. The primary objective of a teaching hospital is to provide the clinical setting for the delivery of health and medical care to patients and for the education of health manpower.

2. Research in the basic medical sciences and laboratory clinical sciences is a secondary objective of a teaching hospital. Research should be considered as a program for the hospital, within readily available facilities and financial resources designated for that purpose. Monies for research should not be considered as hospital revenue.

3. The hospital intends to assure itself, the university, and the public that it can maintain a stable financial position as a not-for-profit institution. Further, it seeks to demonstrate that it must operate from revenues derived from providing services to patients.

4. The hospital seeks to provide space, equipment, and health manpower for rendering care to patients.

5. The hospital, through its relationship with the medical school, seeks to collaborate in carrying out educational programs for health manpower as far as its resources will permit.

6. To carry out its objectives in patient care and education, the hospital must have an organized medical staff.

Problems Encountered in Meeting Objectives

1. With rising payroll, equipment, modernization, and replacement costs, the hospital is having increasing difficulty in meeting financial obligations in view of the level of money resources available to it.

2. The hospital would like to control costs. At the same time, it would like to expand programs and services to patients and staff.

3. The hospital is facing major problems in obtaining capital funds for modernization, replacement, and new construction.

4. As scientific medical knowledge has expanded dramatically, the hospital has increasing responsibility for providing proper medical staff coverage for all patients, at all times.

5. Operating income shortages require the hospital to explore all means of controlling expense and collecting all revenues to which it is entitled. The restrictions under P.L. 89-97 on payment for professional services provided by the associated staff, the faculty, and the attending staff require careful planning and full cooperation between the hospital, its medical staff, and the medical school.

Steps to be Considered in Solving These Problems

1. Define the elements of the hospital's financial position. In order to approach full reimbursement or direct pay for expenses incurred in the operation of the hospital, the full identification of costs and revenues must be refined. These principles are established for hospitals in the American Hospital Association's (AHA) Statement on Financial Requirements of Health Institutions and Services and are supported by the AHA Chart of Accounts.

a. Hospital Operating Costs

Hospital operating costs would include salaries and benefits of all professional and administrative personnel, space, equipment, overhead, and maintenance for:

1. All services rendered to patients.

2. Education of the public and education of health manpower.

3. Research in basic and clinical sciences and in delivery of health care.

4. The administration of patient service, education, and research programs.

5. Certain renovations of the physical plant necessary for operating these programs.

6. Debts which have been incurred in operating the hospital's programs.

b. Hospital Revenue

The identification of all funds available for the operation of the programs of the hospital is necessary to determine the final allocation of monies, from each source, to meet the expenses of the hospital.

1. All revenues personally paid by patients; reimbursement from third-party payors, Blue Cross, Blue Shield, Medicare, Medicaid, Compensation; government allowances for own-paying or partially paying patients; government or other allowances or subsidies for support of hospital patient operations; endowments or special funds used in providing services to patients.

2. All funds from tuition; endowment; foundation; government or private subsidy, gifts, or support; grants; allowances from third-party payors for expenses incurred in the hospital's educational program.

3. Endowments, gifts, subsidies, and allowances from third-party payors or governments; grants or other funds used for research.

c. Capital Funds of the Hospital

Capital funds of the hospital for replacement, renovation, modernization, or expansion of the physical plant; for operation of existing programs; or for development of new ones must be identified.

1. Endowments, gifts, and allowances for capital use.

2. Funded depreciation.

3. Funds from grants or foundations.

4. Monies from governmental or other public or private sources for capital use.

5. Funds available from borrowing.

2. Define the costs of educational programs which are hospital expenses. All the educational programs which are expenses to the hospital should be listed, including internship, residency, continuing education, nursing, medical technology, X-ray technology, etc.

a. Classroom, laboratory and, didactic instruction.

b. Teaching patient rounds, case studies, and similar patient teaching exercises.

c. Grand rounds and clinical conferences.

d. Records review of clinical experience.

e. Library, reading, writing papers, and other similar assignments.

f. Salaries, equipment, space, overhead, maintenance, and administration of program.

g. Time of associated staff and medical staff, nursing staff, etc., spent in the hospital for teaching and administration of teaching programs.

3. Define the reimbursable professional services for rendering in-patient care.

a. Daily and special rounds for patient care.

b. Consultations for patients.

c. Special examination and technical procedures on patients.

d. Diagnostic tests on patients.

e. Treatments, operations, and procedures for therapy of patients.

4. Define the reimbursable hospital services for rendering in-patient care (including acute short-term care, emergency unit care, and intensive care).

a. Hospital technical and professional services, nursing, dietary, and supportive therapies.

b. Bed care services of patients.

c. Ancillary services of laboratory, X-ray, etc., used for in-patients.

d. Administrative support elements of patient care, including personnel, purchasing, shipping, receiving, stores, maintenance, housekeeping, clerical, business, and other general administrative support.

e. Salaries, equipment, space, and overhead.

5. Define the reimbursable services for rendering out-patient care. The ambulatory care, clinic care, or office care of patients is related more to professional service cost and revenue.

a. Time of the medical staff and the associated staff spent in the out-patient department, in rendering services to patients, and in education in the out-patient department, including administration of services and education.

b. Ancillary services of laboratory, X-ray, etc., for care of out-patients.

1. Allocate revenues and expenses of caring for in-patients in the out-patient department and back to the hospital in the in-patient department.

2. Salaries, space, equipment, maintenance, and overhead of out-patient services.

3. General administrative support of out-patient services.

6. Define the hospital's in-patient department arrangement for management of revenue derived from medical professional services of both the associated staff and the medical staff and the related expense. Relate these to the expense of professional salaries.

7. Define the hospital's out-patient department arrangement for the management of revenue derived from medical professional services and the related expense. Relate these to the expense of professional salaries.

8. Define the billing and receiving arrangement for professional services rendered in the hospital's in-patient department.

9. Define the billing and payment receiving arrangement for professional services rendered in the hospital's out-patient department.

10. The source documents used by the hospital as media for professional charging and billing should identify the following for each service rendered.

    a. The in-patient.

    b. The out-patient.

    c. The responsible medical staff physician.

    d. The service rendered.

    e. The charges for the service.

    f. The physician rendering service.

        1. Intern.

        2. Resident.

        3. Senior resident.

        4. Chief resident.

        5. Faculty staff member.

        6. Attending staff member.

    (If rendered by associated staff, it should identify the physician who was present.)

g. The cost center where service was rendered.

h. The hospital or out-patient service which accompanied the professional service.

i. The source of payment.

1. Personal payment.

2. Blue Cross.

3. Blue Shield.

4. Medicare A.

5. Medicare B.

6. Medicaid.

7. Private insurance.

8. Compensation.

9. Industrial-company paid.

10. Other.

11. For each fiscal year, determine eligible staff.

a. Medical staff, by in-patient professional department and division.

b. Associated staff.

1. Intern by professional department.

2. Assistant resident by professional department and division.

3. Resident by professional department and division.

4. Senior resident by professional department and division.

5. Chief resident by professional department and division.

c. Medical staff by out-patient professional department and division.

d. Associated staff by out-patient professional department and division.

1. Intern by professional department.

2. Assistant resident by professional department and division.

3. Resident by professional department and division.

4. Senior resident by professional department and division.

5. Chief resident by professional department and division.

e. Eligible staff.

Generally speaking, third parties will reimburse salaries of hospital, in-patient department staff and will pay professional fees for medical staff services in the in-patient and out-patient hospital departments.

1. Each patient should have clearly identified medical staff physician and associated staff.

2. This indicates the need for each associated staff member to have a clearly identified relationship to the medical staff.

3. Each year the medical staff should consider appointing licensed chief residents and senior residents to the medical staff if they are judged qualified to see patients

independently except for consultation on difficult medical management problems.

4. Each medical staff member must see the patients he has accepted, and the hospital must have a medical staff method for accepting each patient as a medical staff responsibility, in addition to an associated staff responsibility.

12. Define hospital and medical staff organization roles in medical care, education, and finance objectives. To provide a stable base for the hospital to offer medical care to patients and to offer a clinical setting for the education of physicians, the hospital must be able to finance these operations. It must be in a position to bill and collect for all hospital services rendered to patients. If professional staff expenses are borne by the hospital, it must be in a position to bill and collect for professional services rendered.

a. In 1970, all patients should be considered as private in the sense that their care should be personally rendered by the medical staff. The associated staff, whose primary objective is education, may assist the medical staff in rendering care.

b. Departmentalization of the medical staff should be fully implemented in the hospital's in-patient and out-patient services. All physicians, including the associated staff, should be identified with a department and a specialty division.

c. A uniform fee structure should be determined by the medical staff and published within the hospital organization.

d. For a medical staff member to render service, be eligible for payment, and satisfy legal

requirements, he must be available to see patients at all hours, except when he has assigned patient responsibility to a medical staff colleague (not a member of associated staff).

WHEN THE PHYSICIAN WHO PERSONALLY RENDERED OR WAS PERSONALLY PRESENT WHEN THE CARE WAS RENDERED WAS	PAYMENT MAY BE MADE WHEN SERVICES WERE PERFORMED BY					
	MEDICAL STAFF	CHIEF RESIDENT	SENIOR RESIDENT	RESIDENT	ASSISTANT RESIDENT	INTERN
HOSPITAL MEDICAL STAFF MEMBER	YES			YES	YES	YES
CHIEF RESIDENT*		YES		YES	YES	YES
SENIOR RESIDENT*			YES	YES	YES	YES
ASSOCIATED STAFF MEMBER	NO	NO	NO	NO	NO	NO

*ELECTED FOR ONE YEAR TO HOSPITAL MEDICAL STAFF

APPENDIX C

MEDICAL STAFF ELIGIBILITY FOR PAYMENT OF SERVICES