



## **Radio Frequency ID Tracking as a Means to Complete an Emergency Physician Availability Time Study**

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*Author's note: That which follows is an excerpt from a more extensive white paper on this important topic. Please contact me if you'd like a copy of the complete document.*

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The purpose of this paper is to gather resources and citations that specifically address one aspect of Critical Access Hospital (CAH) reimbursement: inclusion of costs associated with Emergency Department Physician (EDP) availability (a.k.a. standby) time in a CAH facility's Medicare Cost Report. In particular, we will focus on methodology regarded by Centers for Medicare and Medicaid Services (CMS) as acceptable for measurement of availability time. We will also explore **ACUTE CARE's** investigation into and implementation of an innovative Radio Frequency Identification (RFID) system designed to simplify the process of recording and reporting accurate data.

CMS' Provider Reimbursement Manual (PRM) is a key resource for this investigation. The following excerpts address general and specific requirements for time studies designed to measure and report availability time.

PRM 15-1, § 2313.2E: Special Applications – Time Studies:

“1. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

2. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

3. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

4. No two consecutive months may use the same week for the study, e.g., if the second week beginning in May is the study week for May, the weeks selected for June and July may not be the second week beginning in those months.

5. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

6. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

The intermediary may require the use of different, or additional, weeks in the study in its response to the provider's request for approval and may prospectively require changes in the provider's request as applied to subsequent cost reporting periods.”

This leads us to acceptable methodologies for time studies... A word of caution here: That which follows is based on generally accepted common practice, deemed acceptable by selected Medicare Fiscal Intermediaries. As I was unable to find citations from CMS specifying methodology, what you'll find recorded here represents observation rather than a directive from CMS. The following list is likely not inclusive. There may be additional, acceptable methodologies available. ***Please consult your Fiscal Intermediary before implementing any of these strategies.***

1. Using the ED Patient Log

In this method, the facility uses the times recorded in the log (which includes time of arrival and discharge for each patient) as the basis of determining when there were no patients in the department. While use of this method provides an indication of when the physician is not engaged in clinical duties (as there are no patients in the department) it is not truly representative of the definition of availability. It is likely that there are instances where there are patients in the department, but the ED Physician is not actively engaged in clinical duties.

2. Using a Time Study Completed by the ED Physicians

As the ED Physicians are responsible for the data regarding their availability submitted by the facility (in their Cost Report) on their behalf, it is logical to provide a mechanism for them to personally record, during each shift during the time study period, their impression of the division of time between clinical and “standby”. This methodology has the advantage of near contemporaneous record keeping by the individuals performing the Medicare-reimbursed services. Its only limitation is the subjective nature of memory and the devotion to accuracy of the physicians.

3. **Radio Frequency Identification (RFID) Tracking**

An emerging possibility for enhancement of accuracy in recording and reporting ED Physician availability time involves implementation of an RFID tag and detector system in the department. **ACUTE CARE** is in the process of utilizing this technology to develop a novel *wireless* RFID system that meets the requirements of our practices. As of this writing, we are proceeding with the

second stage of ED-based testing as the prelude to our first implementation. If you would like to learn more about this exciting new program, please feel free to contact me by phone (800.729.7813) or e-mail ([paulh@acutecare.com](mailto:paulh@acutecare.com)).