A physician’s perspective

The clash of clinical vs. coverage/payment concerns

by Trey LaCharité, MD

An emergency department (ED) physician diagnosed a patient with pneumonia. He was concerned about a possible nosocomial etiology given the patient’s recent hospital discharge for problems related to atrial fibrillation. Because the patient’s Pneumonia Severity Index score was 4 and his CURB-65 score was 2, the ED physician wanted to admit the patient to the hospital for treatment with broad-spectrum intravenous antibiotics. However, after discussion with the ED physician, the admitting hospitalist denied the admission on the grounds that the patient did not meet either InterQual or Milliman criteria for inpatient admission.

According to the hospitalist, the patient had a normal white blood cell count, was not tachypnic or tachycardic, had a normal temperature, and had an oxygen saturation of 98% on room air. While the patient had an extensive past medical history, the only new objective abnormality was an obvious infiltrate on the chest x-ray. The patient looked fine on paper, at least healthy enough to be sent home, the hospitalist said. After discussion, the ED physician agreed and discharged the patient.

I am the hospitalist in this tale. What should I have done? Should I have:

› Admitted the patient to the hospital, risking the future inpatient denial and the subsequent exhausting appeal process?
› Placed the patient in observation status, trusting that the patient would be discharged in a timely manner and knowing that reimbursement from the payer would not cover the cost of the care provided?
› Discharged the patient home with oral antibiotics and close outpatient follow-up with either his primary care provider or through a return visit to our ED?

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Because the patient clinically “looked good” according to the ED physician, I made the suggestion to try outpatient treatment first. The patient received an initial dose of broad-spectrum intravenous antibiotics in the ED and was discharged home with 10 days of oral antibiotics, with a return visit to the ED scheduled in two days’ time.

I’d like to report that the patient returned drastically improved. He didn’t. When he returned 48 hours later he was floridly septic. Fortunately, the patient responded very well to aggressive treatment; two days after the initial admission to an intermediate care unit, he was medically stable for transfer to a general medicine ward. He was eventually discharged back home with home health care.

My gravest concern is that I made a decision I would not have made a little over a year ago. In hindsight, it is blatantly obvious that I allowed my medical judgment to be negatively impacted by my recent experiences fighting medical necessity denials in my role as a physician advisor to CDI and coding.

In the aggressive post-discharge auditing environment where I now find myself practicing medicine, I and my colleagues are subject to heavy scrutiny by CMS and private insurers. Observation versus inpatient status review is the new focus of these nonclinician auditors and has become the reason for the vast majority of my facility’s denials.

This new auditing pressure we all face stems from the completely noble idea that reductions in fraud, abuse, and improper payments will preserve resources for those who truly need medical care. Sadly, as with many commendable aspirations, the execution is poor and often produces a dismal result.

As the physician advisor for CDI, I have been diligently educating every physician at my institution about ensuring the medical necessity of our inpatient admissions. But while CMS asserts that the admitting physician is solely responsible for status selection (i.e., inpatient, outpatient, or observation status), admission status for the physician has no clinical relevance. Physicians do not recognize “conditional” or “partial” admissions, which observation status implies. As far as physicians are concerned, their patients either medically need something or they don’t. Physician education focuses on the development of skills that allow one to discern whether a patient can be safely sent home.

The rules concerning inpatient versus observation status selection are not newly created; CMS’ vague guidelines for appropriate status selection have been around for years. The difference is that CMS and other payers suddenly discovered that they can extend their existing financial resources by “enforcing” those rules.

Payers and their related auditing agents have traditionally avoided the question of whether a patient actually needed the medical care that was provided. Instead, they simply point to inappropriate status selection and deny the associated claim. The issue is whether physicians should be contemplating a patient’s admission status at all.

I have always prided myself on the belief that I do what is best for the patient before me. I never look at the patient’s registration sheet because I do not want to inadvertently prejudice his or her insurance status. Yet the admission judgment I made for the patient described in this introduction was affected by my recent experiences with medical necessity denials.

As a society, do we really want our physicians to be faced with these simultaneous worries? Should nonclinicians be influencing my bedside practice patterns? I am concerned that other physicians will face this same scenario in the future. Is this what we want from our healthcare system? Is this what I want for my family’s medical care?

I understand that financial resources for medical care in this country are finite. I understand that not all care provided in this country is medically necessary and that some individuals take advantage of the current system. However, most entities caring for patients in the United States are simply doing the best they can to comply with today’s regulatory environment while still trying hard to provide the high-quality medical care that their patients trust them to deliver.

One day, I will be a patient, and I hope that the physicians taking care of me at that time do what is in my best interest as opposed to having their clinical judgment influenced by nonmedical considerations such as government audits, threats of fraud, or worries about reimbursement.

Editor’s note: La Charité is a hospitalist and physician advisor for CDI and coding at the University of Tennessee at Knoxville. Contact him at Clachani@UTMCK.EDU.

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Medical Executive Committee Approvals

The following items were presented and actions were approved at the September 11, 2012 Medical Executive Committee meeting:

Treasurer’s Report
A. July/August Treasurer’s Report

Medicine Department
A. Revised Cardiac Diagnosis Required Documentation Form
B. Revised Department of Medicine Rules & Regulations Appendices

Revisions:

Failure to Respond to Code 90
If the physician on call fails to respond to a Code 90 twice within a 3-month 6-month period, the physician will be removed from the EKG Reading Panel. The physician may request to be reinstated on the EKG Reading Panel if they have been compliant with the Code 90 Policy for 1 year from the date of removal from the EKG Reading Panel.

C. New Practice Prerogative Application Card for Allied Health Professional Nurse Practitioner – Cardiology Practice
D. Revised Clinical Privilege Application Card for Department of Medicine – Cardiovascular Disease/Cardiology

Revisions:

42.00 – Cardiovascular Disease/Cardiology Core
Privileges to admit, evaluate, diagnose, provide consultation, perform history and physical exam and treat patients of all ages – except where specifically excluded from practice and except for these special procedures listed below – with cardiovascular disease.

Privileges include, cardioversion, tilt table testing, insertion and management of central venous artery catheters, use of thrombolytic agents, thoracentesis pericardiocentesis, echocardiography interpretation including, holter scanning, treadmill and exercise testing including studies, and peripheral venous cutdown, and electrical cardioversion.

E. Revised Clinical Privilege Application Card for Department of Medicine – Neurology

Revisions:

Experience: Applicants must provide documentation of inpatient care for at least 50 patients as an attending physician or resident during the past two years. Excludes applicants requesting only telemedicine privileges.

XX.XX – Telemedicine Reading of Intraoperative Neuromonitoring (IONM) – Intraoperative Evoked Potentials (SSEP), Electromyography (EMG), Triggered EMG (tEMG), motor evoked potentials (MEP), Electro-encephalography (EEG) and brainstem auditory evoked potentials (BAEP)
Qualifications: Training in this procedure must be verified by neurology residency or neurology subspecialty fellowship
Proctoring Requirements: 2

# cases required Init App: 50
# cases required Reapp: 50

F. Revised Clinical Privilege Application Card for Department of Medicine – Pulmonary Disease

Revisions:

XX.XX – Endobronchial Ultrasound Needle Aspiration/Biopsy
Qualifications: 1. Hold Pulmonary Core 49.00; 2. Documentation of Training Completion (Certification)
Proctoring Requirements: 0

# of cases required Init App: 0
# of cases required Reapp: 10

G. Revised Rules & Regulations for Department of Medicine, Article VI – Consultation

Revisions:

Consultation is specifically urged in the presence of the following conditions:

2. Complicated cardiac conditions myocardial infarction

Obstetrics and Gynecology Department
A. Division of Nursing Obstetrics Policy/Procedure entitled, “Scheduling of Inductions and Cesarean Sections”
B. Revised Clinical Privilege Application Card – Department of Obstetrics and Gynecology: Female Pelvic Medicine and Reconstructive Surgery

Revisions:

Addition of Privilege 98.79: Da Vinci Surgical Platform and Assistant Da Vinci Surgical Platform.

Continued on page
Medical Executive Committee Approvals
The following items were presented and actions were approved at the September, 2012 Medical Executive Committee meeting:

Pediatric Department
A. Revised Clinical Privilege Application Card for Department of Pediatrics – Gastroenterology and Endoscopy
Revisions:
Deletion of 44.15-Liver Biopsy (includes Percutaneous and/or needle approach) 44.17-24 or 48-hour pH Interpretation
# of cases required Init App: 10 2
# of cases required Reapp: 5 2
B. New Clinical Privilege Application Card for Department of Pediatrics – Pulmonary Disease
C. Revised Clinical Privilege Application Card for Department of Pediatrics – Critical Care
Revisions:
XX.XX – Basic Ventilator support management < 48 hours Burn unit only
# of cases required Reapp: 5 2
XX.XX – Pulmonary artery (Swan Ganz) catheters Burn unit only
Qualifications: 1. Documentation of completion of a Pediatric Critical Care Fellowship; 2. Documentation of training during fellowship; or 3. Board Certified in Pediatric Critical Care
# of cases required Init App: 4 2

71.31 – Vasoactive Drug Drips Burn Unit only

71.32 – Invasive Monitoring Burn Unit only
Qualifications: 1. Documentation of completion of a Pediatric Critical Care Fellowship; 2. Documentation of training during fellowship; or 3. Board Certified in Pediatric Critical Care

Bylaws Committee
A. Revised Medical Staff Services Policy/Procedure entitled, “Disaster Privileges”
B. Revised Medical Staff Services Policy/Procedure entitled, “Professional Practice Evaluation”
C. Revised Medical Staff General Rules and Regulations
Revisions:
Section C. MEDICAL RECORDS
6. Operative and Other Procedure Documentation Requirements (RC.02.01.03 EP5-7)
EP5: An operative or other high-risk procedure report shall be written or dictated upon completion of the operation or other high-risk procedure and before the patient is transferred to the next level of care.
Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure in which case the full report can be written or dictated within 48 hours after the operation or procedure.

Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

EP6: The operative or other high-risk procedure report includes the following information:
Name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
2. The name of the procedure performed
3. A description of the procedure
4. Findings of the procedure
5. Any estimated blood loss
6. Any specimen(s) removed
7. The postoperative diagnosis

EP7: When a full operative or other high-risk procedure report cannot be entered immediately in to the patient’s medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes:
1. The name(s) of the primary surgeon(s) and his or her assistant(s)
2. The name of the procedure performed
3. A description of the procedure
4. Any estimated blood loss
5. Any specimen(s) removed
6. The postoperative diagnosis
The provisional diagnosis before the operative or other high-risk procedures shall be recorded. (RC.02.01.03 EP2)

An operative or other high-risk procedure progress note, as an abbreviated report, is entered in the medical record immediately after the procedure. (RC.02.01.03 EP7)

The medical record contains the following postoperative information:

a. The patient’s vital signs and level of consciousness. During operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient’s oxygenation, ventilation, and circulation are monitored continuously. The hospital assesses the patient’s physiological status immediately after the operative or other high-risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia.

b. Any medications, including intravenous fluids and any administrative blood, blood products, and blood components.

c. Any anticipated events or complications (including blood transfusion reactions) and the management of those events. (RC.02.01.03 EP8)

The full operative/procedure report shall be written or dictated and authenticated as soon as possible (48 hours) after the procedure.

G. EMERGENCY DEPARTMENT CALL PANEL

By action of the Medical Executive Committee on September 12, 1995, all Active, Associate, Courtesy and Provisional (where proctoring has been successfully completed), staff members will be required to provide emergency department call coverage. This includes in-house coverage, when requested, by the physician on the ER Call Panel the day of the request, not the day the patient was admitted to the hospital. Excluded from call coverage are Affiliate staff members, Honorary staff members, Retired staff members and Provisional staff members (who have not completed their proctoring). Required call will be assigned according to the physician’s primary specialty unless otherwise specified. Any physician assigned for ER call coverage will also be required to provide coverage for patients admitted to the hospital as requested by the attending physician. If the physician on ER Call or their designee is unavailable, the Department Chief (of the concerned department) will be called upon to resolve the situation.

Credentials Committee – Approvals filed in Medical Staff Services – please see Toni Woodard.

Infection Control/P&T Committee
A. Formulary Review: DaTscan, Totect®, Oncaspar, Halaven, Voluven
B. Potassium IV Administration
C. Epidural Continuous and PCEA Infusion Orders
D. IV Guideline Changes
E. Adult Parenteral Nutrition Orders

Institutional Review Board – Approvals filed in Medical Staff Services – please see Yumi Lee.

Nominating Committee
Nominations for 2013 Medical Staff Officers
• Secretary/Treasurer: Vinh Cam, M.D.
• Assistant Chief of Staff: Eric Milefchik, M.D.
• Chief of Staff: Thomas Simko, M.D.
• Members-at-Large: John Abe, M.D., Garrett Matsunaga, M.D, Brian Miura, M.D., Alex Shen, M.D., Aileen Takahashi, M.D.
## CME CONFERENCES

**Wednesdays, 12:30 pm**  
Health Conference Center

Torrance Memorial Medical Center is accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA) to provide continuing medical education for physicians.

Torrance Memorial Medical Center designates this live activity for a maximum of 1 AMA PRA Category I credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This credit may also be applied to the CMA Certification in Continuing Medical Education.

For up-to-the-minute conference information call (310) 784-8776.

### Medical Staff Calendar

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<th>Monday</th>
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<td>8:00a TCU Committee………..WT-C</td>
<td>7:00a CV Review Conference.WT-D</td>
<td>7:00a Breast Tumor Board…WT-Aud</td>
<td>7:00a Surgery Dept………..WT-Aud</td>
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<td>12:30p Infection Control/P&amp;T….WT-C</td>
<td>12:30p CME Conference…..HCC 1&amp;2</td>
<td>7:30a Tumor Board………..WT-Aud</td>
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<td>7:30a IRB Committee………..WT-D</td>
<td>5:00p Professional Relations…WT-C</td>
<td>7:00a Anesthesia PI………WT-Aud</td>
<td>7:00a Breast Tumor Board…WT-Aud</td>
<td>7:00a Vascular Medicine……WT-C</td>
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<td>7:30a Physician Alignment…..WT-B</td>
<td>6:00p Medical Executive……WT-D</td>
<td>7:00a CV Review Conference.WT-D</td>
<td>7:30a Tumor Board………..WT-Aud</td>
<td>7:00a Surgery Advisory……..WT-D</td>
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<td>12:30p Credentials…………….WT-C</td>
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<td>12:30p CME Conference…..HCC 1&amp;2</td>
<td>12:30p Medicine PI………..WT-B</td>
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<td>7:00a Cardiotoracic Surgery.WT-C</td>
<td>12:00p Radiology Dept………..WT-Aud</td>
<td>7:00a CV Review Conference.WT-D</td>
<td>7:00a Breast Tumor Board…WT-Aud</td>
<td>7:00a Vascular Medicine……WT-C</td>
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<td>12:00p Burn &amp; Wound…………WT-C</td>
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<td>7:30a Tumor Board………..WT-Aud</td>
<td>7:00a Surgery Advisory……..WT-D</td>
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<td>4:00p Bariatric Surgery……….WT-D</td>
<td>12:30p OB/GYN Dept………..WT-Aud</td>
<td>7:00a CV Review Conference.WT-D</td>
<td>7:00a Breast Tumor Board…WT-Aud</td>
<td>7:00a General Surgery……….WT-C</td>
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<td>12:00p General Staff………..HCC 1&amp;2</td>
<td>12:00p Family Practice Dept…..WT-B</td>
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<td>12:30p Bioethics……………WT-B</td>
<td>12:30p Tumor Board………..WT-Aud</td>
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<td>12:30p Credentials…………VT-C</td>
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<td>12:30p Health Info. Mgmt……WT-B</td>
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<td>7:00a CV Review Conference.WT-D</td>
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- **October 3, 2012**  
  “Hepatitis A, B & C”  
  Sammy Saab, M.D.  
  UCLA School of Medicine  
  Commercial Support: Gilead

- **October 10, 2012**  
  “Functional Bowel Diseases”  
  Christopher Chang, M.D.  
  UCLA School of Medicine  
  Commercial Support: None

- **October 17, 2012**  
  NO CONFERENCE

- **October 24, 2012**  
  NO CONFERENCE

- **October 31, 2012**  
  NO CONFERENCE

- **November 7, 2012**  
  “Ventilator-Associated Pneumonia”  
  Hidenobu Shigemitsu, M.D.  
  USC School of Medicine  
  Commercial Support: None

- **November 14, 2012**  
  “Medication Safety”  
  Jody Jacobsen Wedret, Ph.D.  
  UCI Medical Center  
  Commercial Support: None
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<tbody>
<tr>
<td>Jean R. Allard, M.D.</td>
<td>Cardiothoracic Surgery</td>
<td>575 E. Hardy St., Ste. 322, Inglewood, CA 90301</td>
<td>(310) 671-0488</td>
<td>(310) 671-7618</td>
</tr>
<tr>
<td>Timothy S. Kristedja, M.D.</td>
<td>Hematology/Oncology</td>
<td>3440 Loma Blvd., Ste. 250, Torrance, CA 90505</td>
<td>(310) 530-9763</td>
<td>(310) 784-1704</td>
</tr>
<tr>
<td>Rama E. Chandran, M.D.</td>
<td>Orthopedics</td>
<td>4477 West 118th St., Ste. 402, Hawthorne, CA 90250</td>
<td>(310) 644-1151</td>
<td>(310) 644-3115</td>
</tr>
<tr>
<td>Heidi A. Limkemann, M.D.</td>
<td>Hematology/Internal Medicine</td>
<td>3330 Loma Blvd.—HCP 1st Floor, Torrance, CA 90505</td>
<td>(310) 784-8770</td>
<td>(310) 784-4991</td>
</tr>
<tr>
<td>Shaun E. Chandran, M.D.</td>
<td>Orthopedics</td>
<td>4477 West 118th St., Ste. 402, Hawthorne, CA 90250</td>
<td>(310) 644-1151</td>
<td>(310) 644-3115</td>
</tr>
<tr>
<td>William M. Luxford, M.D.</td>
<td>Otolaryngology</td>
<td>2100 W. Third Street, Los Angeles, CA 90057</td>
<td>(213) 483-9930</td>
<td>(213) 484-5900</td>
</tr>
<tr>
<td>Stephanie Wei-Ying Chen, M.D.</td>
<td>Pediatrics/Internal Medicine</td>
<td>550 Deep Valley Dr. Ste. 319, Rolling Hills Estates, CA 90275</td>
<td>(310) 544-6858</td>
<td>(310) 544-6855</td>
</tr>
<tr>
<td>James S. Pratty, M.D.</td>
<td>Psychiatry/Addiction Medicine</td>
<td>21081 S. Western Ave., Ste. 250, Torrance, CA 90501</td>
<td>(310) 217-8877</td>
<td>(310) 224-5290</td>
</tr>
<tr>
<td>Genevieve L. Hasek, M.D.</td>
<td>Emergency Medicine</td>
<td>Torrance Emergency Physicians, Inc. 3330 Loma Blvd.—Emergency Dept., Torrance, CA 90505</td>
<td>(310) 325-9110</td>
<td>(310) 784-3789</td>
</tr>
<tr>
<td>Maria E. Rhoads-Baeza, M.D.</td>
<td>OB/GYN</td>
<td>20911 Earl St., Ste. 480, Torrance, CA 90503</td>
<td>(310) 370-7277</td>
<td>(310) 542-8893</td>
</tr>
<tr>
<td>Lily Honris, M.D.</td>
<td>Hospitalist/Internal Medicine</td>
<td>Torrance Memorial Hospitalists Assoc. 3330 Loma Blvd.—TMHA 1st Floor, Torrance, CA 90505</td>
<td>(310) 891-6623</td>
<td>(310) 891-6673</td>
</tr>
<tr>
<td>Houman Saedi, M.D.</td>
<td>Vascular Surgery</td>
<td>Association of South Bay Surgeons 23451 Madison St., Ste. 340, Torrance, CA 90505</td>
<td>(310) 373-6864</td>
<td>(310) 373-9547</td>
</tr>
</tbody>
</table>
Welcome

New Practitioners on Staff

Yasmeen Shaw, M.D.
Hospitalist, Pulmonology, Critical Care Internal Medicine
HealthCare Partners Hospitalists
3330 Lomita Blvd.—HCP 1st Floor
Torrance, CA 90505
Phone: (310) 784-8770
Fax: (310) 784-4991

Peter B. Shin, M.D.
Family Practice
3440 Lomita Blvd., Ste. 427
Torrance, CA 90505
Phone: (310) 326-2161
Fax: (310) 534-5026

Von A. Ta, M.D.
Hospitalist, Internal Medicine
Torrance Memorial Hospitalists Assoc.
3330 Lomita Blvd.—TMHA 1st Floor
Torrance, CA 90505
Phone: (310) 891-6623
Fax: (310) 891-6673

Khaled A. Tawansy, M.D.
Pediatric Ophthalmology
7447 N. Figueroa St. Ste. 200
Los Angeles, CA 90041
Phone: (323) 257-3937
Fax: (323) 257-3200

Physician Roster Updates

Change of Address/phone/fax:

Elaine Jones, M.D.
Fax: (310) 939-7861
Specialty: Internal Medicine

Sunil Rangappa, M.D.
325 N. Maple Dr., Ste. 5104
Beverly Hills, CA 90209
Phone: (310) 890-2364
Fax: (310) 366-4666
Specialty: Cardiology

Shirlene Jay, M.D.
3400 Lomita Blvd., Ste. 503
Torrance, CA 90505
Phone: (310) 257-1988
Fax: (310) 257-1897
Specialty: Dermatology

John Kennedy, M.D.
20911 Earl St., Ste. 200
Torrance, CA 90503
Phone: (310) 909-4851
Fax: (424) 257-8215
Specialty: Cardiology

Ali Morshed-Meibodi, M.D.
20911 Earl St., Ste. 200
Torrance, CA 90503
Phone: (310) 214-3278
Fax: (310) 793-9000
Specialty: Cardiology

The Medical Staff Newsletter Progress Notes is published monthly for the Medical Staff of Torrance Memorial Medical Center.

Thomas G. Simko, M.D.
Chief of Staff

Robin S. Camrin, CPMSM, CPCS
Vice President, Medical Staff Services & Performance Improvement
Torrance Memorial’s Planned New Patient Tower

Medical Staff Services

3330 Lomita Boulevard
Torrance, CA 90505
Phone: (310) 517-4616
Fax: (310) 784-8777
www.TorranceMemorial.org