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INSIDE

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Patient access now has new KPIs — Compare your department to peers

Data is only way to justify needed resources

Too often, patient access leaders lack good metrics to show how well, or poorly, the department is doing. This situation puts patient access at a big disadvantage.

"We tend to not have as good data as the back end. Because of that, we don't always tell our story as well as we should," says **Yvonne Chase**, MBA, CHAM, manager of revenue cycle at Mayo Clinic's Phoenix and Jacksonville, FL, sites. Chase is president of the National Association of Healthcare Access Management (NAHAM).

"YOU CAN'T GO TO SENIOR LEADERSHIP AND SAY 'WE NEED FTEs,' JUST BECAUSE VOLUMES HAVE INCREASED." — YVONNE CHASE, MBA, CHAM, PRESIDENT OF NAHAM

Without valid key performance indicators (KPIs), patient access struggles to justify the need for resources. "Data must become a top priority to validate what staff you need and why you need it," says Chase. "You can't go to senior leadership and say 'We need FTEs,' just because volumes have increased."

The current state of peer-to-peer comparison in patient access is "all over the map," says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle management at Emory University Hospital in Atlanta. Some departments use MAP (Measure, Apply, Perform) Keys, which are revenue cycle benchmarks, from the Healthcare Financial Management Association (HFMA). Some patient access leaders query their peers at other organizations informally. "Others rely on consultants, who may or may not have an underlying business motive," says Kraus. "Still others feel pretty helpless in finding a source they can trust."

In January 2015, NAHAM introduced its AccessKeys: 23 KPIs that track how the front end is performing in point-of-service collections, private-

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EDITORIAL E-MAIL ADDRESS:
joy.dickinson@ahcmedia.com.

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For questions or comments, call Joy Dickinson at (404) 262-5410.

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pay conversions, process failures, productivity, and quality. *(See related stories on AccessKeys and HFMA MAP Keys in this issue. To learn more about AccessKeys, which are free to NAHAM members, go to www.naham.org/AccessKeys.)*

Good data allows patient access departments to call attention to their successes, such as having a wait time of two minutes when the industry standard is five minutes. "These indicators give people the opportunity to make a case for what they need to be one of the best patient access departments in the industry," says Chase.

Hold staff accountable

At Texas Health Harris Methodist Hospital Southwest Fort Worth, employees in patient access services always have "a mindset of improvement and advancement. If we do not know how we fare, if we have no expectation or goal, we will fail our organization and our community," **Laura Rasor**, director of patient access services.

The department uses a Patient Access Indicator Report, developed internally, with more than 65 indicators. These are displayed in green if the goal is met and red if the goal is not being met.

"Communication boards are required in all departments of the hospital. This is where I post our reports," says Rasor. Patient access and revenue cycle leaders used the HFMA MAP Keys for guidance to develop the targets.

"Patient satisfaction is an effort that is hot on everyone's plate. But the Indicator Report also encompasses the basics of patient access, to include collections and quality of work," says Rasor.

The department uses surveys only from Boston-based Press Ganey to compare itself against its peers. "It is helpful to see how we fare in comparison to facilities that are similar in size. We certainly learn from each other's wins and opportunities," says Rasor.

Each month, patient access leaders pull 10 random accounts for each employee to score them on accuracy. Staff starts with a 3.00 score. Specific points are assigned to each component of the registration, such as appropriate documentation and correct insurance code and policy number. If a component isn't met, points are deducted.

"Our system also has an automated quality assurance tool that alerts representatives of possible errors," says Rasor. "Managers monitor that tool to confirm our staff are utilizing it and making the

EXECUTIVE SUMMARY

Patient access departments often lack good data to demonstrate successes and justify the need for resources. Patient access can use AccessKeys, new key performance indicators (KPIs) developed by the National Association of Healthcare Access Management, to do the following:

- Determine if the department falls into "good," "better," or "best" categories.
- Demonstrate how additional FTEs will affect KPIs.
- Boost morale by spotlighting successes.

necessary corrections in accounts."

Like many patient access departments, the one at Emory University Hospital is expected to meet various annual goals, such as dollars collected prior to admission and patient satisfaction scores. However, the ability to gauge how those numbers compare to other patient access departments has been a continual challenge.

How the department's goals compare to industry standards "is conjecture at best," says Kraus. "Until now, no one has provided a pathway to evaluate where a department is, what it will take to move it to where it wants to be, and compare progress with peers."

Because patient access departments differ from other areas of the hospital, unique KPIs are needed that take those differences into account. "Access expectations are different from those of other departments," Kraus explains. "Patient accounts in particular, sometimes seems to work at odds with patient access."

Fast registration times conflict with the need to collect complete, accurate information, for example. Likewise, short wait times make it difficult to provide caring, personal attention to all patients. Similarly, high pre-admission cash collection rates might be at odds with the goal of superior patient satisfaction scores.

"But we need to stop thinking that upfront collections automatically will compromise the scores," says Kraus. "I am convinced that these goals can be reconciled successfully."

SOURCES

- Yvonne Chase, MBA, CHAM, Manager, Revenue Cycle, Mayo Clinic, Phoenix, AZ. Phone: (480) 342-4472. Fax: (480) 342-3633. Email: chase.yvonne@mayo.edu.
- Pete Kraus, CHAM, CPAR, FHAM, Business Analyst, Revenue Cycle Management, Emory University Hospital, Atlanta. Phone: (404) 712-4399. Fax: (404) 712-1316. Email: pete.kraus@emoryhealthcare.org.
- Laura Rasor, Patient Access Services, Texas Health Harris Methodist Hospital Southwest Fort Worth. Phone: (817) 433-6600. Email: LauraRasor@texashealth.org.
- Sandra J. Wolfskill, FHFMA, Director, Healthcare Finance Policy, Healthcare Finance Management Association, Westchester, IL. Phone: (708) 531-9600. Fax: (708) 531-0032. Email: swolfskill@hfma.org. ■

NAHAM president urges strategies for AccessKeys

Many patient access leaders are happy to have AccessKeys, which are key performance indicators (KPIs) from the National Association of Healthcare Access Management (NAHAM), reports **Yvonne Chase**, MBA, CHAM, manager of revenue cycle at Mayo Clinic's Phoenix and Jacksonville, FL, sites.

However, they aren't confident in how to use this new tool. "The biggest question we are getting is, 'How can I roll this out in my department?'" says Chase, NAHAM's current president.

To address this need, NAHAM is developing a toolkit and online blog to help patient access departments implement AccessKeys. "Once you put a couple of these in place, you will find they are really not that difficult," says Chase.

At many smaller hospitals, patient access staff members still do everything manually. "We recognize that many departments can't afford automated tools," says Chase. "But they still need to measure themselves against something that is realistic."

She suggests that patient access leaders consider these approaches for using AccessKeys:

• Choose an indicator based on your biggest pain point.

The KPIs can tell you if your department is in "good," "better," or "best" categories, in comparison to peers. "Average wait times were big for us, and the downside was possible cancellation and/or delay of care," says Chase. For this KPI, the department started at the "better" category and is working toward being the "best."

In some healthcare systems, patient access staff members measure large amounts of data, but don't learn anything meaningful about their problem areas. "Some people measure nothing, while some people do it ad nauseum, but it's not always valuable data," says Chase.

• Choose an indicator for something the department already does well.

"Put that out there for staff," says Chase. "It's eye-opening for them to see that 'we were good, we are getting better, but this is what we have to do to be the best.'" She suggests starting with point-of-service collections. "It's easy to track, and staff love to see how they compare to other departments within patient access," says Chase. "Create a healthy competiveness amongst staff."

• Find out what other data already is being collected that might be useful to patient access.

"What we are finding is, if you reach out to some of the finance people, they already have a lot of these numbers," says Chase. "Plug the

numbers in, post them, and tell your story."

For example, claims denials and return mail ratio often is tracked by billing and accounts receivable. "Often, the clean claim rate can be directly associated with the registration accuracy rate," says Chase.

• Use the KPIs to justify the need for additional FTEs.

"You have to measure productivity across the board, holding staff accountable," says Chase. "Unless you have good data, it's really difficult to do."

The ability to measure staff productivity allows Chase to permit some registrars to work from home. Some experienced registrars relocated, but they still are employed by the department. "Data is the only way I can know that a teleworker is productive," she says.

Some patient access departments go short-staffed because they're unable to show the need for additional FTEs. This short staffing results in claims denials and dissatisfied patients. "If the MRI staff is there waiting and they have to tell the patient there is no authorization, and you've had it in the queue for a week, they look at us, patient access staff, as the obstacle," says Chase.

Some departments need more FTEs to keep up with payer requirements. The KPIs allow patient access to show hospital administrators that an additional FTE would decrease claims denials.

"You can show senior leaders 'We're just 'good' right now, and we need these resources to get to 'better,'" says Chase. "You can show what you need, whether that's electronic tools, more bodies, or more training."

Access departments vary

Because the tasks performed by patient access departments vary widely depending on the organization, it's difficult for KPIs to accurately compare one to another. Some of AccessKeys' KPIs tie into NAHAM's Registration/FTE Calculator, which addresses the disparity in areas of responsibility by different patient access departments.

Pete Kraus, CHAM, CPAR, FHAM, business analyst for revenue cycle management at Emory University Hospital in Atlanta, says, "They will become more refined as users adopt them and share their results with NAHAM and its members. Unlike the HFMA MAP (Measure, Apply, Perform) Keys, which tend to track easily measurable data points, AccessKey measurements are more subtle and nuanced due to the nature of the business."

Good/better/best ratings make NAHAM's AccessKeys valid and comparable in the context of the wide variety of tasks patient access staff might be expected to perform.

"The ratings are often based on the level of technology and responsibility an access department has," says Kraus.

If a patient access department is not responsible for pre-certification, for example, it might have to settle for a lower rating in terms of overall error-free accounts. "The goal is to make AccessKeys both measureable and meaningful for all access departments, irrespective of level of sophistication," says Kraus. "This isn't easy." ■

Are patient access staff accountable? Be sure that they are with KPIs

Lack of accountability is a primary concern for patient access departments lacking good key performance indicators (KPIs).

"Staff respond to what we measure and communicate to them," emphasizes **Sandra J. Wolfskill**, FHFMA, director of healthcare finance policy and revenue cycle MAP (Measure, Apply, Perform) at the Healthcare Finance Management Association (HFMA).

Many patient access leaders use HFMA's MAP Patient Access Keys to track revenue cycle performance. "These give the patient access director a strategic-level snapshot of patient access performance," says Wolfskill. The MAP Keys use these KPIs:

• Point-of-service cash collections.

High patient satisfaction scores are related to lower accounts receivable (A/R) days and higher point-of-service collections, according to HFMA's 2009 report *Strategies for a High-Performance Revenue Cycle.*

"The key is having the financial conversation with patients prior to service, or at the time of service for non-scheduled patients," says Wolfskill.

• Service authorization rate.

"Payers are enforcing the preauth rules," warns Wolfskill. "Providers need to make sure that is done before service, or payers can and will deny the claim."

• Pre-registration rate.

A low pre-registration rate could indicate that the organization doesn't have a lot of scheduled business.

More likely, it means that scheduling, clinical areas, and patient access are not working together to pre-register every scheduled patient prior to the patient's arrival for service.

"To understand the potential impact, one only needs to identify the total volume of scheduled patients across all departments within the organization and compare that to the number of those patients who have been pre-processed prior to service," says Wolfskill.

The pre-registration rate KPI reveals the gap between those two numbers. "The access director can identify the opportunity to increase this percentage to close to 100%," says Wolfskill. "This positively impacts patient satisfaction, as well as the financial clearance process."

Higher percentages mean more patients are financially cleared prior to service. "This also allows staff to conduct their financial communications work with the patients prior to service," says Wolfskill. "That is the appropriate time for scheduled accounts to be resolved."

• Insurance verification rate.

"Why would any organization *not* want to make sure that the correct payer source has been identified before sending a claim to a payer?" asks Wolfskill.

The insurance verification rate shows what percentage of accounts are verified. This step ensures that the provider is sending the claim with the right identification information to the right payer.

"If the provider is experiencing a significant number of payer denials in the 'unable to identify subscriber' category, then the current verification process should be expanded to include all accounts," says Wolfskill. This process will reduce denials in this category.

• Conversion of uninsured patients to a payer source.

"Running batch files of self-pay accounts against the state Medicaid files is one way to quickly identify and confirm coverages," says Wolfskill. ■

Write-offs due to patient access mistakes cut in half — More than $100,000 saved

Reasons for costly errors were discovered

Write-offs due to mistakes made by patient access employees were cut in half at Saint Louis (MO) University Hospital by determining the root cause of insurance eligibility claims.

"Patient access write-offs in 2013 were $212,499, and in 2014 they were $92,533," reports **Lillian Cortivo**, director of patient access services.

The billing department provides a list of disputed claims to patient access and case management. "We meet weekly to identify trends to eliminate for the accounts being disputed," says Cortivo.

Here are two problems they identified:

1. Denials often occurred because an authorization was given for one CPT code, but an additional procedure was performed.

"That is one of the biggest reasons for claims denials," Cortivo says. "We have done a few things to address this." These changes were made:

• Every day, the department receives a report showing the CPT codes that were authorized.

"It shows what was approved and what is being billed out," says Cortivo. "If there is any difference, it will catch it before insurance receives it."

• If needed, patient access employees quickly contact the payer to get the authorization updated.

"Usually if we catch it the day of the procedure, the insurance will give the authorization. On a few occasions, they won't," says Cortivo.

• Patient access educated technicians in ancillary departments about the need to obtain authorizations for every CPT code.

EXECUTIVE SUMMARY

Write-offs resulting from errors made by patient access were cut in half at Saint Louis (MO) University Hospital. After identifying root causes of denials, the department made changes.

- Staff compare what was approved with what is billed, to identify additional CPT codes.
- Technicians are to obtain authorizations for each CPT code.
- Patient access contacts physicians' offices at least seven days before scheduled procedures.

"If the technician sees something is added, they contact patient access right away. We then contact the insurance company to get that authorization," says Cortivo.

• Patient access contacts physician offices at least seven days prior to scheduled procedures, to make sure required authorizations are in place.

Staff members document on each account, "This authorization is for these codes." "If the facility identifies that the auth is not in place for a specific code, we contact the provider office," says Cortivo. "They update the auth to capture the code."

2. Some claims were denied for patients admitted through the emergency department because patient access couldn't get the insurance information upfront.

If the patient is moved to a rehabilitation facility, patient access typically doesn't get the information until several days later. "We document each and every time we attempt to visit a patient and attempt to collect that information," says Cortivo. "Usually if we can prove we didn't have the information, they will pay the claim."

Patient access leaders at Wilmington, DE-based Nemours/Alfred I. duPont Hospital for Children are closely monitoring "no-auth" denials.

"We recently split them into more focused categories to assist with solving the underlying issue for the denial," says **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization/care management.

Denials are put into these categories: payer is not participating, code changes in which one code was authorized but a different code was billed, and capitated lab/imaging site denials. "Denials lumped into one big 'no-auth' category did not allow us to understand why the visit or procedure was denied," says Atkins.

A "code changes" spreadsheet is used by the authorization specialists and the outpatient procedure coder. "The coder is able to quickly add cases to the spreadsheet for the auth specialists to work daily, to request authorization for the changed or added codes," Adkins explains.

Previously, staff allowed the additional code to bill, then appealed the "no-auth" denial on the back end. The new process lets the added procedures get authorized on the front end. "It's not perfect, as some payers have strict timelines on requests," says Adkins. "But we have seen a definite improvement."

The department also changed its primary care physician referral process. "The improved referral process decreases the amount of time it takes to submit the referral," Adkins says. "It also decreases errors in transcription." This process leads to fewer claim denials for no authorization or incorrect codes.

Previously, staff manually printed and faxed the referral. For imaging studies, staff members called the provider's office the day of the visit to authorize the test. "Now all faxing is completed within the Epic system, with no need to get up and wait in line for the central fax machine," says Adkins.

The department also developed a referral request form that automatically pulls in patient demographic info, which saves time and improves accuracy. This form is sent to the primary care physician requesting the referral.

"We are also working with different services to get a better understanding of imaging or lab studies that are typically ordered with a specific diagnosis, such as fractures," says Adkins. A return visit for a fracture results in an X-ray 95% of the time, for example. "We are developing a tool to assist the authorization specialist in knowing what to request to authorize the appropriate X-ray," says Adkins.

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- Lillian Cortivo, Director, Patient Access Services, Saint Louis (MO) University Hospital. Phone: (314) 268-5086. Email: lillian.cortivo@coniferhealth.com. ■

These registrars' customer service is excellent — in *clinical* areas

Patient satisfaction has become a top priority for patient access, and not just in registration areas.

"Everyone knows healthcare is quickly becoming a service-based industry," says **Christopher R. Jones**, MBA, patient access manager for emergency department (ED) and outpatient registration at Mission Hospital in Asheville, NC.

Every point of contact is a chance for Mission's registration team to demonstrate excellent service to a patient. This contact might be in an elevator, in the cafeteria, in

the hallway to a meeting, or in the parking lot. "The success of our interactions can have everything to do with whether the customer chooses to repeat their business or go somewhere else," says Jones.

Patient access needs to exceed patients' expectations "from the time the patient presents to the site until the end of their services, and even long after that," says **Janet James**, MBA, patient access manager of emergency and outpatient registration at Thomas Jefferson University Hospital in Philadelphia.

Here are some examples of excellent service provided by patient access in clinical areas:

• After a patient is admitted at San Diego-based Sharp Healthcare, a patient access team member visits the patient at the bedside.

The employee gives the patient a folded card with an inspirational thought for the day, such as "The journey of a thousand miles must begin with a single step." The card displays the hospital's logo and the main admitting office phone number.

"We created a 'Memorable Moment' requirement for all access service areas," explains **Gerilynn Sevenika**r, vice president of patient financial services.

Patient access employees use this scripting: "Good morning/afternoon. My name is ____ from registration. I just wanted to come up and say good morning/afternoon, and see if there is anything I can assist you with. I would like to leave you with a thought for the day (read message). This is part of our contribution to leave you with a memorable experience at Sharp Memorial Hospital. (pause). Is there anything else I can assist you with before I go?"

At Sharp Mary Birch Hospital for Women & Newborns, patient access staff members deliver a message to new mothers on "seed" paper, which can be used to grow flowers. "It is an out-of-the box moment to connect with our patients and make sure the experience is better than expected," says Sevenikar.

EXECUTIVE SUMMARY

Patient access employees can go outside their departments and roles to improve patient satisfaction, even in clinical areas.

- Registrars at Sharp Healthcare deliver a greeting card to admitted patients.
- Emergency department registrars at Mission Hospital cleaned rooms during high-volume periods.
- A registrar at Thomas Jefferson University Hospital alerted clinicians to a piece of possibly life-saving medical information.

• ED registration supervisors at Mission Hospital, helped to turn over beds on a high-volume day, so patients didn't have to wait any longer.

On that particular day, the Environmental Services team was working very hard to turn over the rooms as quickly as possible, but for every room cleaned, there was another room vacated that also needed cleaning. "There were a number of patients waiting for beds to be cleaned so they could be admitted," Jones explains. "It was a daunting task, indeed."

Two direct admit patients waiting for an inpatient room to become available were getting more frustrated with each passing minute. Both registration supervisors went to the clinical floor to help Environmental Services clean the two needed rooms.

"This is one of the truest examples I have seen of not only teamwork and leadership, but also putting the words 'patient-centered' into action," says Jones. "They did what was necessary to solve a problem."

• An ED registrar brought potentially life-saving information to the attention of clinicians at Thomas Jefferson University Hospital.

A non-English speaking child presented to the ED with a fall injury, accompanied by a grandmother who also didn't speak English and was communicating through an interpreter. After being examined for injuries, the child was about to be discharged. One of the ED registrars reviewed the packet of material that the grandmother had presented during registration.

"She found a school note that actually described a syncopal episode as the reason for the child's ER visit," says James. Based on this new information, the ED physician completed additional follow-up, which revealed that the child had pneumonia and was dehydrated. The child was given intravenous fluids and antibiotics, and the child was admitted to the hospital.

"This story shows that we're all part of the patient team, regardless of our title," says James.

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- Janet James, MBA, Patient Access Manager, Emergency and Outpatient Registration, Thomas Jefferson University Hospital, Philadelphia, PA. Phone: (215) 955-9697. Fax: (215) 503-1475. Email: Janet.James@jefferson.

edu.
- **Christopher R. Jones**, MBA, Patient Access Manager, Mission Hospital, Asheville, NC. Phone: (828) 213-1931. Email: Chris.Jones2@msj.org.
- **Gerilynn Sevenikar,** Vice President, Hospital Revenue Cycle, Sharp HealthCare, San Diego. Phone: (858) 499-4215. E-mail: gerilynn.sevenikar@sharp.com. ■

'High patient dissatisfaction' until wait times in registration were cut from 20 minutes to 8

A new fast track process is used in the department

Patients often complained about the lengthy waits and the registration process at some radiology and breast health departments at Sacramento, CA-based Sutter Health.

"There was high patient dissatisfaction, due to backlogged waiting rooms and disjointed processes. We now have a fast track process in place, with average wait times at five to eight minutes," says **Becky J. Peters**, system director of patient access services at Sutter's Shared Services Center in Roseville, CA, which houses the health system's newly created Patient Access Center.

Previously, says Peters, "We had very little true preregistration or financial clearance prior to services." Most patients had to complete a full registration and pay out-of-pocket balances, prior to service. "We had dissatisfaction issues with patient wait times and delay in services, from both patients and clinical departments," says Peters.

To shorten wait times, the department implemented a pre-service model for registration. Staff members at the centralized Patient Access Center complete pre-registration, financial clearance, and financial counseling in a single phone call.

"At our Oakland facility, we had patient wait times averaging 20 minutes," says Peters. "Preregistration is now completed for 70 to 80% of our scheduled patients, who are then able to be fast-tracked." Average wait times for patients to complete a full registration are now five to eight minutes.

"Once an appointment is scheduled, it populates our Patient Access Center work queues," explains Peters. "It is then segmented to the appropriate work team." These steps occur:

1. The scheduling department transfers the call to a financial clearance representative.

2. The financial clearance representative completes a full pre-registration. "He or she verifies eligibility and benefits, confirms authorization if required, provides a price estimate based on the scheduled service, and collects," says Peters.

3. Staff refer patients who need help with their out-of-pocket responsibility to a financial counselor, who assists them with payment plans and/or charity screening.

4. The Patient Access Center team informs the patient, "Since you have completed the preregistration process, you can proceed directly to the department on the date of service. You will receive a speedy check-in."

A daily appointment report flags patients as a "Go" or "Stop." If the indicator is "Go," registrars know the patient has completed preregistration. In this case, they just need to scan the patient's insurance and identification and have the patient sign the consent form.

If the indicator is "Stop," then the patient needs to complete a full registration. "This may be due to the preregistration process being incomplete, or the patient may have to make a payment," says Peters.

At Children's Healthcare of Atlanta at Egleston, patient access

EXECUTIVE SUMMARY

Patient access leaders at Sutter Health often fielded complaints from patients about registration wait times. A new pre-registration process cut average registration wait times of 20 minutes to under eight minutes.

- Sutter Health patients are scheduled and pre-registered in a single phone call.
- Patients who have completed pre-registration at Sutter Health have a speedy check-in process.
- Day surgery patients are registered at the bedside at Children's Healthcare of Atlanta at Egleston.

recently switched to bedside registration at the hospital's 30-room day surgery department. Improving patient satisfaction was the biggest motivating factor for this change, says patient access manager **Michelle H. Crumbley**, CHAM.

"Our waiting room is not very large. During our busiest days, folding chairs are brought out, and we have families waiting out by the elevator," she explains.

With limited space, there wasn't enough privacy during the registration process.

"Patients are now brought directly back to their assigned room," says Crumbley. "Patient access comes to them." This process is used:

- Upon arrival, patients are greeted by a registration coordinator and are signed in.
- The Day Surgery team provides a list of the day's room assignments to the greeter.
- A patient care assistant brings the patients back to a room. "Once in a room, they can now be more comfortable. The child can even lay down or watch TV," says Crumbley.

Registrars use a wheeled computer to register the patient, collect out-of-pocket costs, and obtain signed consent forms.

- An electronic status board lets physicians and nurses know the patient is in a room. "Registration turns a light on above the door, once they are finished" to alert clinical staff members that they can now come into the room to begin treatment, says Crumbley.

"We've seen many benefits from this process," says Crumbley. "We have brought together patient access and nursing."

When registration was done in the waiting room, patient access and clinical staff members had no contact with one another. "But our impact on each other was huge," says Crumbley. "We now share in a common goal, and our teamwork shows."

Physicians now can see their patients between surgery cases, since the patient is already in a treatment room. "Before, patients might have been sitting out in the waiting area waiting for registration," says Crumbley.

Family members are much less anxious and more comfortable being in a private room. "They are more willing to pay their copay in a private, relaxed environment," she says. "And patient access staff feel more a part of the clinical team caring for the patient."

Customer service scores, registration wait times, surgery first start times, and turnaround times are all being measured. Because the process just started in January 2015, little data is available.

"But even without these numbers, the success is evident by walking out into the waiting room," says Crumbley. "There are no more folding chairs and no long waits."

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- Becky J. Peters, System Director, Patient Access, Sutter Shared Services Center, Roseville, CA. Phone: (916) 297-9004. ■

Team up with providers on pre-cert requirements that are 'much more aggressive' — It's a necessity!

Patient access dealing with pushback from payers

Janice "Mae" Williams, manager of precertification at Memphis, TN-based Methodist LeBonheur Healthcare's Centralized Services Division, recalls having a "wow" moment during the first week of January 2015. Insurance carriers had put into place more requirements before issuing prior authorization for diagnostic and surgical procedures.

"The rules get more stringent each year," Williams says. "What amazes me is we can go to the insurance company's website and do exactly what it says, only to be denied and have them say, 'We haven't updated our website yet.'"

Such denials sometimes can be successfully appealed, but this appeal process requires a large amount of rework. "We've challenged a lot of them, and some insurance companies will not pay retroactively," Williams says. "They are now saying, 'If you don't get the precert on the front end, I'm sorry, that's your loss.'" *(See related story in this month's issue on how the department prevents clinically related denials.)*

Commercial payers are "much more aggressive" regarding medical necessity at the time of issuing authorization, as well as during claims processing, according to **Mary Lee DeCoster**, former vice president of revenue cycle at The Maricopa Integrated Health System (MIHS) in Phoenix, AZ.

Payers are demanding much

more clinical information before they'll give an authorization, and that requirement means providers' offices need to be involved. "High-cost diagnostics, including MRIs and PET scans, are getting a lot of attention from the medical review perspective prior to service," says DeCoster. DeCoster is vice president of consulting services for Adreima, a Phoenix-based revenue cycle services firm. Adreima is assisting MIHS with recovering revenue associated with clinically related claims denials.

To obtain authorizations, MIHS created a central Referral Center, part of the ambulatory registration services department. All requests for services are routed from the ordering physician to the Referral Center. "A staff of specialists, with clinical support, work to secure the authorization prior to care," says DeCoster.

The physicians can rely on the expertise of the Referral Center's specialists to secure authorizations. "They notify the physician when the patient's coverage does not include benefits for the service ordered or when the patient must be referred outside of the MIHS," says DeCoster.

In the health system's fully integrated Epic system, each patient has one record throughout the system, including clinics, the hospital, the ED, or urgent care. "All of the primary care records are available to the referral specialist," DeCoster notes.

Orders are entered electronically into the MIHS' clinical physician order entry system.

"Each order requires a supporting diagnosis supporting the services ordered," says DeCoster. Rules are built into the Epic system that alert a physician when a diagnosis does not support the services being ordered.

The managed care department gets involved in cases where there are questions regarding contractual terms or requirements. Some claims are successfully appealed based on the clinical documentation contained in the medical record. "Any claim denied due to medical necessity is reviewed by a nurse auditor," says DeCoster.

In one such case, a victim of a motor vehicle accident was brought to MIHS, which is a Level I Trauma Center. "Initial surgery and stabilization was provided," says DeCoster. The insurance plan wanted to transfer the patient to another facility because the hospital does not contract with the plan.

"The managed care department was able to negotiate an arrangement specific to this patient," says DeCoster. "The patient was able to stay at MIHS, ensuring continuity of care."

SOURCES

- **Mary Lee DeCoster**, Vice President, Consulting Services, Adreima, Phoenix. Phone: (602) 636-5600. Fax: (602) 265-3693. Email: Marylee.decoster@adreima.com.
- **Janice "Mae" Williams**, Manager, Precertification, Centralized Services, Methodist LeBonheur Healthcare, Memphis, TN. Email: Janice.williams@mlh.org. ■

EXECUTIVE SUMMARY

Patient access staffs are challenged to work much more closely with providers' offices to provide payers with required clinical information and to avoid denied claims.

- Route all physician orders to a referral center that obtains authorizations.
- Alert physicians electronically when a diagnosis does not support the services being ordered.
- Have nurse auditors review any claim denied due to medical necessity.

Department made these changes to stop 'no auths'

According to Memphis-based Methodist LeBonheur Healthcare's policy, if a physician sends a patient to a facility for an outpatient test, the test is still done, even if the precertification is not yet in place.

"It's part of the service we are trying to provide for our patients and our physicians," says **Vicki Boyd**, director of the hospital's centralized services division and former director of patient access services. "But if it's 4 p.m. on a Friday and the plan won't retroactively give the precert, it's going to be written off."

Here are some changes the department has made to prevent clinically related denials:

• Staffing is increased as needed to obtain precertifications.

In some cases, staff members scramble to obtain required authorizations before the close of business. "We make sure to staff appropriately to meet those timeframes," says Boyd. "We have a

committed team of precert specialists who will do whatever it takes to get that precert secured."

Staff members sometimes stay later, come in earlier, or work on a Saturday or holiday. "The good of the patient always comes first," says Boyd. "But without appropriate reimbursement, we could not stay in business to provide that service."

• Staff obtain approval for medications or implants that might be used during surgery, if these require separate precerts.

Increasingly, payers are requiring authorizations for specific medications or for implants used during a surgical procedure. To prevent denials, employees now attempt to obtain approval before surgery for items that potentially could be used.

"We now get the authorizations on the 'possibles,' so these will be covered if they're used," says **Janice "Mae" Williams,** manager of precertification at the hospital's Centralized Services Division. "We also instructed the scheduling team that if any implant is involved, to name it on the front end."

• Staff membes ask, "Is this a covered benefit?"

Payer reps sometimes tell the precertification specialist that no precertification is required for a particular service. "What they don't tell you is that it's not necessarily a covered benefit," says Williams.

For example, nutrition is not necessarily a covered benefit for a chemotherapy patient, even though it's part of the patient's plan of care. "The key is not to have the patient or the facility surprised on the back end," says Williams.

• Patient access staff members ask physicians to have a "peer-to-peer" conversation with the payer's physician if a high-dollar claim is denied for clinical reasons.

Prior to giving approval, the patient's carrier might ask the physician to do a peer-to-peer conversation if a high-dollar claim shows the potential of being denied for non-substantiated clinical reasons. "Or the provider can request a peer-peer to push the procedure through," says Williams. "In talking to another clinician, they may decide that the care is appropriate and approve it."

• The surgical team quickly notifies case management of any changes or additional procedures.

In some cases, precertification was obtained for the patient's surgery, but additional procedures were done during the surgery that weren't anticipated. This results in the entire claim being denied.

Boyd says, "If you miss a couple of those, it can be devastating to your bottom line."

Quick notification that additional procedures were done avoids many denials. However, some have slipped through because the surgical team didn't notify case management in a timely manner. "We found that all of those occurred on the weekend," says Boyd. "We are trying to bridge that communication gap."

• The surgical team notifies patient access if precertifications are not in place by noon the day before surgery is scheduled.

"That gives us the next four hours to get the precertification," says Boyd. "It also lets case management, surgery, and patient access know that the surgery may need to be moved to later in the day."

SOURCE

- Vicki Boyd, Director, Centralized Services, Methodist LeBonheur Healthcare, Memphis, TN. Email: vicki.boyd@mlh.org. ■

Healthcare Access Personnel Week offers opportunity to celebrate with your staff

National Healthcare Access Personnel Week is scheduled for April 5-11, 2015, and is a weeklong celebration of people in the patient access profession. The date marks the anniversary of the National Association of Healthcare Access Management (NAHAM).

"We provide quality care in patient registration and all of its support processes to patients, providers, and payers throughout a patient's healthcare experience," NAHAM said. "Not only do we represent the first impression, becoming the face for the entire facility, but we also serve as the key component in putting

COMING IN FUTURE MONTHS

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- Monitor productivity of registrars working from home
- Novel ways to celebrate collection successes, at zero cost

every healthcare visit in motion. It all starts and ends with patient access management, and we truly do pave the road to success for our patients and our facilities!"

Supporting National Healthcare Access Personnel Week demonstrates to your employees that you appreciate their efforts and encourage them as "goodwill ambassadors for the entire hospital," NAHAM said. A recognition program during this week enhances guest relations, increases staff morale, and improves communications, the organization said.

If your hospital has a newsletter, a feature article on the access department can appear that week, suggested NAHAM, which provides a sample newsletter article at http://www.naham.org/?page=Newsletter. Local newspapers often have sections highlighting various community events and can help draw attention to the celebration, NAHAM said. "Displays describing the work, growth, and/or evolution of the department or spotlighting on the access department's employees can be set up in a central, heavily traveled part of the hospital," the organization suggested.

NAHAM has created a complimentary toolkit to assist you with planning a recognition program with free puzzles and games for you to engage your staff. It provides numerous suggestions for events and contests you can implement and offers a list of audiences you should remember during your celebration.

"You can also purchase a variety of specially designed products for use throughout the week and entire year as recognition gifts and reminders of your department's important contributions to the operation of the hospital," NAHAM said.

Go to http://www.naham.org/?page=Main to access the following:

- suggested Access Week activities;
- an Access Week toolkit;
- a sample press release;
- a sample memo to send to the marketing department;
- an official proclamation.

NAHAM suggests that patient access deprtments consider these activities:

- Conduct a 'Get to Know Us' survey, and give each participant a gift (i.e. popcorn/candy, etc.).
- Arrange a catered lunch for your staff.
- Have a daily trivia contest with prizes.
- Publish information with registration statistics and other information in the hospital newsletter.
- Have staff members vote for peers in assorted categories, such as Most Accurate, Most Likely to Succeed, Highest Cash Collector, and Best Customer Representative.
- Hold a luncheon for your CHAMs and invite your COO, CIO, CEO, or CFO.
- Have a speaker discuss a topic relating to the workplace or access.
- Give a flower to each staff member with a thank-you note from the manager, director, and/or vice president.
- Hold a story board or discussion session to share goals and ideas toward making your department better.
- Hold an open house for family members of access staff.
- Hold a recognition luncheon for access staff.
- Hold an employee and volunteer open house.
- Honor your physicians and their office staff. ■

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