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FEBRUARY 2016 Vol. 35, No. 2; pp. 13-24

## INSIDE



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*HIPAA Regulatory Alert:* Can you report patients with mental health issues to the national database?

AHC Media

# Access successfully cuts A/R days — Registration errors drop by 30%

Registration-related billing errors dropped by more than 30%, as a result of an organization-wide focus on reducing accounts receivable (A/R) days at Stanford Children's Health, reports revenue cycle operations director **Shawn Tienken**.

"We've also seen over a 25% improvement in claims resolution efficiency," he says.

Tienken is chair of the organization's Revenue Cycle Workflow Committee, which is improving revenue cycle workflows to reduce A/R. The committee includes managers from patient access, authorizations, health information management, patient financial services, and information systems.

"Our entire revenue cycle team is focused on billing and collecting appropriate payment as quickly and accurately as possible," says Tienken.

Much collection-related work traditionally performed by hospital business office staff has shifted to patient access, notes **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Hospitals in Atlanta. "All aspects of the revenue cycle are priorities of access, reducing A/R days conspicuously so," says Kraus. "This has helped bring access front and center among hospital departments." He says patient access can take the following steps to maintain low A/R days:

"IF ACCESS DOES ITS JOB WELL, IT WILL BE CONTRIBUTING MAXIMUM SUPPORT TO MAINTAINING LOW DAYS IN A/R."
— PETE KRAUS, CHAM, CPAR, FAHM, EMORY HOSPITALS

- Confirm demographics and data for billing earlier in the process.
- Obtain correct diagnoses and procedures to calculate accurate estimates of insurance and patient liability.
- Collect patient balances upfront.
- Give staff the ability to determine exactly what insurance will pay.

"If access does its job well, it will be contributing maximum support to maintaining low days in A/R," Kraus emphasizes.

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AHC Media

Stanford Children's switched to a new electronic health record (EHR) in 2014.

"We used that as an opportunity to implement a new 'distributed A/R' philosophy," says Tienken.

Previously, the organization relied on back-end business office staff to clean up errors caused by front-end activities. The new distributed A/R approach moves accountability for registration and billing accuracy to the registrars who initially captured the data.

"If you were a front-desk person who didn't record all of the required insurance information for a patient, then we wanted to push that incomplete record back to you to fix," says Tienken.

Patient access staff monitor a dash-board that shows which areas are making errors or causing denials, and how much money is at risk. "Our new EHR has claims and billing modules integrated directly into registration and clinical systems," says Tienken. "We are able to tie these processes together more easily and create alerts when things go awry."

Patient access staff worked with the hospital's information services team to create tools in the new EHR system to increase registration accuracy. "This makes it easier for registration staff to collect and document the right information, while they are interacting with the patient," says Tienken.

The system alerts registrars if something looks wrong, such as an invalid subscriber ID format, an unverified insurance coverage, or a missing digit in the zip code of the billing address. Previously, says Tienken, errors such as these resulted in denials, claim rejections, or other payment delays.

"Most alerts can be fixed immediately," says Tienken. If not, this delay usually is because the employee is rushing to get the patient into service. In some cases, the employees don't have the information they need at their fingertips. For example, the employee might be taking registration information on a transfer patient via phone, and the person on the other end doesn't have the valid insurance information to resolve the alert.

"In cases where the issue isn't fixed immediately, visit records with unresolved errors or missing information are routed to a work queue for the clinic manager or department manager to review and resolve," says Tienken. These work queues hold the claim back from billing until the problem is fixed. "There is a lot of visibility and pressure placed on patient access leaders to minimize such instances,"

## EXECUTIVE SUMMARY

Registration-related billing errors dropped by more than 30% as a result of an organization-wide focus on reducing accounts receivable days at Stanford Children's Health. These successful approaches were used:

- Accountability for registration and billing accuracy was moved to the registrars who initially captured the data.
- Correct diagnoses and procedures were obtained to calculate accurate estimates of insurance and patient liability.
- Exactly what insurance will pay was determined earlier in the process.

he says.

Revenue cycle leaders generate weekly dashboards on work queue activity for executive leadership. "They will follow up with department managers if error volumes and dollars start to spike," says Tienken. "This further enhances our culture of accountability."

## Insurance is focus

Patient access and financial services trainers at Danbury-based Western Connecticut Health Network make correct selection of insurance information a primary focus.

"If the correct information is selected, it reduces A/R days," says **Valerie Macelis**, MBA, CHAA, patient access/financial services trainer. "If we get the information to the insurance company correctly, we get paid a lot quicker."

Macelis has found inservice classes to be most effective in reducing A/R days. "Staff are required to listen to the subject matter and ask questions if they don't understand," she explains. "Sending an email doesn't guarantee that employees will read it."

Unfortunately, patient access managers sometimes don't have the correct information themselves about a new insurance plan. When the Health Insurance Marketplace exchange plans came out in 2014, it took patient access trainers several months to figure out how to train employees.

"We did not have any cards to look at, or any information on how to distinguish an exchange plan from a regular insurance plan," says Macelis. When trainers called an exchange hotline for assistance, they sometimes were given misinformation. "We had to figure things out on our own through the Internet, word of mouth, and the pamphlets the insurance companies sent us," says Macelis.

Trainers instructed registrars to identify exchange plans by looking for the word "exchange" or bronze, silver, gold, or platinum colors. In general, they encourage staff to examine insurance cards more closely, because exchange plan cards look almost exactly like regular insurance cards.

"Staff was really quick to just assume it is an off-exchange plan," says Macelis. "They had to change their mindset." If the correct plan is identified, payment will be received more promptly, she says, "and A/R days will be reduced."

### SOURCES


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# Payers want two weeks to review auth requests

*Patient access employees on hold up to 45 minutes*

As if there aren't already enough roadblocks to obtaining authorizations, payers are now requiring unrealistic timeframes to review these requests.

"Most payers are now requesting at least 10 to 14 days to review a case prior to rendering an authorization," reports **Stacy Hutchison-Neale**, CRCR, supervisor of the hospital pre-authorization department at Nemours Alfred. I. DuPont Hospital for Children in Wilmington, DE.

"In a perfect world, this timeframe would be fine. But we are working with sick children and the demands of service to be rendered, sometimes the same day," says Hutchinson-Neale. The department takes these steps when facing time crunches with authorizations:

**• Patient access keeps providers informed at all steps of the authorization process so there are no surprises.**

When patient access receives a request within a 10-day timeframe for non-participating insurance companies, or within a five-day timeframe for participating insurance companies, staff members immediately notify the provider that the authorization request has been received and worked but is pending.

**• Patient access asks if the service can be postponed, which allows the**

### EXECUTIVE SUMMARY

Payers are requiring more time to review authorization requests, which causes patient access to reschedule procedures in some cases.

- Alert providers of new time requirements.
- Create a spreadsheet listing timeframes for specific procedures.
- Inform patients if the authorization is not yet in place.

**insurance company time to render a determination on the case.**

"If the service cannot be delayed, then we submit a full detailed request to administration to review the request for services," says Hutchinson-Neale.

Requests then are reviewed for medical necessity. **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization, says, "I look at the child's previous clinic visits, imaging and lab studies, and/or hospital documentation to determine the medical urgency of the request." For example, she determines if the child is in pain, if the child will suffer specific consequences if the service is delayed, and whether the diagnosis and treatment plan fits with the requested service.

"If the documentation is unclear, or I believe more information is required, I will reach out to the ordering provider," says Adkins.

In some cases, patient access is able to justify that the authorization is required in a shorter timeframe than the payer requires, when the clinical information demonstrates the need to have the procedure, test, or admission initiated as soon as possible. "This may mean a peer-to-peer conversation with the plan's medical director or a letter of medical necessity," says Adkins.

**• The authorization specialists, even if they have administrative approval from the hospital, continue to work with the insurance company to ensure that the approval is secured.**

Hutchinson-Neale says, "We contact the payers for status of the authorization request every two days, for routine cases, and daily for pressing cases."

She is noticing longer hold times when making calls to payers. "Call times range from 15 to 45 minutes, if not more, depending on the coverage," she says. "Some plans with longer wait times can have us tangled in a case for more than an hour with hold time."

If all needed documentation from the provider is not readily available, the process of follow-up calls can last for days. Adkins says, "We encourage our providers to ensure that all medical justification for a case is notated in the chart for easy access." This justification includes the medical reason for the procedure, medication dosages, instructions for infusions, and the plan of care.

Hutchison-Neale says, "When the information is readily available in the chart, it alleviates the amount of callbacks the physician authorization team needs to make to the insurance company."

## Access is "in the middle"

Some payers are taking up to 14 days to respond to authorization requests, reports **Lynn Arrington**, CHAM, director of insurance verification at Arlington-based Texas Health Resources.

"A couple of years ago, payers weren't so driven on timeframes as they are now," Arrington says. "The payer determines the timeframe. If the payer has a 14-day timeframe, we are at their mercy." Physicians often want to schedule patients within two or three days, but insurers slow the process down. "They are looking to make sure the patient really needs the procedure, and the doctor wants to hurry up and schedule it," says Arrington. "We are in the middle."

The department created a spreadsheet listing insurance verification precertification turnaround times for high-tech radiology procedures by payer, and it shared the spreadsheet with providers' offices and the scheduling department. *[The spreadsheet used by the department is included with the online issue. For assistance accessing your online subscription, contact customer service at customer.service@AHCMedia.com or (800) 688-2421.]*

"Communication between scheduling and the providers' offices is key," says Arrington. Payers want detailed clinical information and peer-to-peers, which further complicates the process. "After they receive all of the required information, that's when the clock starts," she says.

To add complications, some payers are specifying that only the physician's office can start the authorization process. "The payer will even go so far as to include this information in our contracts that our managed care department negotiates with them," says Arrington.

Schedulers use this scripting when talking with providers' offices: "Have you obtained an authorization for this procedure? What is the authorization number? If authorization is needed, will you be obtaining that for the facility as well?"

Some patients opt to reschedule if the authorization isn't in place. If the patient chooses to go forward regardless, he or she is asked to sign a non-coverage letter. "If we are not confidant that an account is going to be financially secure with an auth prior to services, then we are ultimately liable for the account," Arrington explains. *(See related story in this issue on "no auth" claims denials.)*

### SOURCES


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# 50% of denials are overturned

*With auth requests, 'there is always a catch'*

"No auth" denials make up about a third of total claims denials at Nemours Alfred. I. DuPont Hospital for Children in Wilmington, DE, estimates **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization.

Reasons for denials include that the service is experimental, that the service did not meet medical necessity, or that the service required a prior authorization. About half of denials are overturned after they're appealed, however, says Adkins.

Authorization specialists copy and paste all responses regarding the authorization into the electronic medical record, including diagnosis and procedure codes and eligibility information. **Stacy Hutchison-Neale**, CRCR, supervisor of the hospital pre-authorization department, says, "This helps the central business office and the utilization management team to appeal claims if need be, to get the denial overturned."

If the response was received by phone, staff members obtain the call's reference number so the call can be reviewed, if necessary. In some cases, they've found that the payer representative approved the case to move forward or gave inaccurate information. "We have noticed there are often discrepancies from what the provider's website states about authorization requirements compared to what a representative says," notes Hutchison-Neale.

Many times, payer reps state, sometimes incorrectly, that no authorization is required for services. "Even though we are provided a reference number for the call, when the claim is submitted, we may get a denial for the request because it actually needed an authorization," says Hutchison-Neale.

The denials always are appealed on the back end, often successfully, but payment is delayed. "Lag time with the provider websites has increased," Hutchison-Neale says. "If we notice that an issue is going on with the website, there is never an easy fix." It can take weeks or even months for it to be corrected. "This means that the authorization team has to troubleshoot and do work-arounds on a daily basis," says Hutchison-Neale.

Patient access is taking extra time to review payer clinical policy guidelines for medical and pharmacy. "When calling insurance companies for pharmacy-related authorizations, there is always a catch," says Hutchison-Neale.

Many times, patient access is told no authorization is required for a medication, even when all codes are provided. Once the claim has been processed, however, the story changes. "We may get notification that there was a denial because it needed to come from a specialty drug pharmacy, which requires a separate authorization," says Hutchison-Neale.

The authorization team came up with a new process to avoid these denials. "Not only do we obtain authorizations through the medical insurance company; we also obtain authorizations through the specialty drug company for the medication," says Hutchison-Neale. Patient access reviews payers' clinical guidelines to ensure that medication is billable through the medical policy and not required through the specialty pharmacy.

"The insurance company does not always provide that information," explains Hutchison-Neale. "If the medical policy does not outline the process for us, we are at the mercy of the insurance rep." ■

# 'Sense of urgency' needed for ED registrations

*Registrars need speed and accuracy in the emergency department*

In addition to great customer service skills and a thorough knowledge of insurance, emergency department (ED) registrars need "a sense of urgency," says **Candace Koutsoulieris**, ED patient access manager at Florida Hospital Orlando.

"The patient's experience begins at the registration desk, and our clinical partners heavily depend on our speed and accuracy," Koutsoulieris says. Here are some ways Florida Hospital's

ED registrars improve patient flow:

**• ED registrars ask the right questions to expedite the initial registration process, then have patients go immediately to the triage nurse.**

Staff use this scripting: "Hi. Are you here to see a doctor this morning/afternoon/evening? Can I please have two forms of ID? Please enter your social security number on the keypad. That allows me to find your medical information."

"We verify information, protect the patient's identity, and weed out the visitors from actual patients," says Koutsoulieris. On average, the ED registers about 350 patients a day.

**• ED registrars make expediting registration the top priority.**

"Collections is very much a core part of our role. However, we decided to move our main focus to the patient experience," Koutsoulieris says.

The top priority for registrars now is expediting the registration process and ensuring the correct health plan is selected. "We hand out surveys that ask about the registration process, and we are doing phenomenal," says Koutsoulieris.

**• ED registrars locate the patient's correct medical record number.**

Koutsoulieris instructs staff to always start the search with the patient's social security number. "That is the only patient identifier that cannot be duplicated, because it's a unique number for every patient," she explains.

**• Ensure the correct health plan is selected and that the patient's demographics are up to date.**

This step is handled by the department's benefits representatives. "They observe anything that is necessary to complete the account," Koutsoulieris says. "They then notify team members on the tracking board that benefits were added."

Patient access staff members then visit patient rooms to verify demographics and collect copays. "It's imperative that we confirm with the patients they have been seen by a doctor and have a plan of care before discussing collection or insurance," Koutsoulieris adds.

**• Registrars place a green sticker on the patient's armband to notify the nurses that this patient was seen by registration.**

This step helps move ED patients out the door quicker. "Nurses can discharge patients at any point, instead of directing them to the patient access discharge window, where they'd have to wait a bit longer to get their registration completed," explains Koutsoulieris.

Simply getting access to the patient is a challenge for ED registrars at Portland-based Maine Medical Center.

"We are often circling the rooms and trying to get in," says **Patty A. Johnson**, CHAM, manager of ED registration. "We never know who is going to be in there and what they are doing."

Registrars often attempt to get into the room several times before completing the patient's registration. "The doctor walks in, or somebody from radiology or labs comes in, and they want us out," Johnson explains.

Previously, registration was completed before the patient was brought back to a room. It took an average time of six minutes to complete the registration. "We used to register them right when they came in the door, but we don't do that anymore, in order to get them to a bed sooner," says Johnson.

Registrars now do a quick check-in, and the patient is brought either to a treatment room or the waiting room, where registration is completed. "Patients like being brought back more quickly, but it now takes us an average of 17 minutes to complete the registration," says Johnson.

Even after the registration is complete, the registrar has to go outside the room to scan documents, which adds time to the process.

Some information obtained by registrars can affect the patient's clinical care, Johnson emphasizes. "Of course, the patient's clinical treatment comes first, but there are some key pieces that clinicians need to know about," she says. These key pieces include the patient's legal next of kin and minors who present for treatment without parents or legal guardians. "Prescriptions and follow-up care are sometimes based on the patient's health insurance," adds Johnson.

The department is looking at implementing electronic alerts that

## EXECUTIVE SUMMARY

Emergency department (ED) registrars can improve patient flow by getting the correct information at the right time in the ED visit.

- Ensure that the correct health plan is selected and that demographics are up to date.
- Place a sticker on the patient's armband to notify nurses that this patient was seen by registration and can be discharged.
- Use electronic alerts to let registrars know they can enter treatment rooms.

tell registrars when it's OK to come in and register the patient. "We are trying to figure out a workflow that will get our completion times down," says Johnson.

The ED is switching to a "first-in, first-out" approach to complete registrations based on the order patients present, which is the model used by the admitting office and call center.

"Other areas seem to have good luck with that approach. It might not work in the ED, but we're going to try it," says Johnson. "We want to see if that will improve our scores."

### SOURCES

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# Want to boost collections? Training is the key, say patient access leaders

*At one hospital, an additional $10,000 was collected in one month in the ED*

Collections in the emergency department (ED) increased by $10,000 the first month after a training and incentives program was implemented at University Hospitals Case Medical Center in Cleveland.

"The more training and support you can provide the staff, the more successful the cash collections will be," says patient access services trainer **Despina Cuva**, CHAA.

Accurately understanding insurance benefits is a major focus of the training provided to patient access employees. "It is very important for the staff to know the difference between deductibles and out-of-pocket costs, and for them to be able to explain these costs to the patient," says Cuva.

All financial counselors at Lawrence (MA) General Hospital completed the Westchester, IL-based Healthcare Financial Management Association's Patient Financial Communications Training Program. *(For more information about the program, go to http://www.hfma.org/pfcprogram.)*

**Gregory Kanetis**, MPA, director of patient financial services, says, "It exposed them to how to connect with the patient, understanding their fears about what the bill will be, and addressing concerns."

Next, the department will roll out the program to all registrars and the pre-registration group. "Patient access staff traditionally haven't had the skills to deal with financial conversations and asking for money," says Kanetis.

The department recently started recording registration and financial counseling conversations with patients. "We are going to take the information we learn about how registrars and financial counselors conduct an interview, and how we can improve, in terms of hitting those points with patients that are important," says Kanetis.

A good quality registration is one priority, with accurate demographic and insurance information obtained, but managers also want to get a sense that the patient feels well cared for. "We will use a subset of those call recordings to see how well we are doing with connecting with the patient," says Kanetis.

If patients learn that they have gaps in their insurance coverage, for example, managers want registrars to inform them about programs to supplement their coverage that the patient might be eligible for. "We will develop role-playing scenarios based on what we hear in the recorded calls," says Kanetis, adding that he has found this type of training to be particularly effective for reluctant collectors.

"We take real-life experiences, ranging from a highly cooperative

### EXECUTIVE SUMMARY

Emergency department registrars collected an additional $10,000 the month after a training and incentives program was implemented at University Hospitals Case Medical Center.

- Ensure staff thoroughly understand insurance benefits.
- Record registration and financial counseling conversations.
- Use role-playing scenarios based on actual patient interactions.

patient to one who is completely disengaged and won't offer any information at all," he says. Here are some scenarios the department has used:

• a patient with a language barrier;

• a patient with dementia who is accompanied by a family member;

• a difficult, uncooperative emergency department patient who is shouting at the financial counselor;

• a patient with no insurance and a prior balance;

• a patient with a very high deductible who is eligible for secondary insurance from the state.

Registrars, billers, and financial counselors play the role of patients. "It's all about repetition — practice, practice, practice, so you can handle questions with confidence," Kanetis says.

Staff members sometimes speak without confidence or hesitate before answering a patient's question. "This interjects doubt from the patient perspective — Does he or she really know what they are taking about?" says Kanetis. "We want them to make mistakes in a controlled environment, not out in public." *(See related story in this issue on how patient access can reduce bad debt.)*

### SOURCES


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# Get money upfront, and reduce bad debt

Collections weren't much of a priority when copays were just $5 or $10, according to **Gregory Kanetis**, MPA, director of patient financial services at Lawrence (MA) General Hospital.

"Now, the dollars are more significant," he says. "What we are trying to do is get the money in the door quicker and reduce our bad debt."

Kanetis looks for new hires with a financial or customer service background, whether in healthcare or not, such as prior experience in retail, hotels, or banks. "We have modified job descriptions to address this need," he reports.

Cleveland, OH-based University Hospitals (UH) Case Medical Center made these changes to increase its collections:

**• Each month, someone is awarded prizes for the most cash collected and the most times a payment was taken.**

"This is one of our most successful way to get staff collecting," says **Despina Cuva**, CHAA, patient access services trainer at UH Case Medical Center. Points are given, which the employee can use to purchase items on the hospital's employee recognition website.

Employees from all collection areas have an opportunity to earn the incentive. "The ED is measured only against fellow patient access representatives in the ED; radiology is measured only against other radiology reps," Cuva explains.

**• The department has started using a program that gives a more accurate estimate of what the patient will owe.**

The estimate is based on the CPT codes submitted by the surgeon and the benefits obtained from the patient's insurance. "The patients appreciate knowing what their liability will be before they have the procedure," says Cuva.

Previously, estimates were completed only for self-pay patients, and it was a manual process. "We always collected co-pays, but this tool has allowed us to expand to quoting deductibles and co-insurance for procedures, tests, and surgeries," says Cuva. ■

# Providers have 'one-stop shopping' for transfers

San Francisco-based UCSF Medical Center recently implemented an Integrated Transfer Center (ITC). Patient access and clinical units work together to clinically and financially clear transfer patients.

"Our providers wanted one-stop shopping," says **Melanie Mata**, the ITC's manager. When providers called about a patient they wanted brought in for an urgent admission, or a patient who was being transferred from another facility, they wanted to be connected to the appropriate resources.

"In the old days, nursing units called each other to move patients from one unit to another," says Mata. "It was not a coordinated process."

Epic's Bed Planning module

allows patient access to see the status of available beds on the various units. "But we had to restructure our processes before that software solution would work," says Mata.

A nurse was added to work with the intensive care unit (ICU) to prioritize patients. "At times, multiple patients are all vying for ICU beds at the same time," Mata explains.

Previously, the process went through the admissions department. "But they weren't able to collect what the patient's clinical needs were and determine if we had a bed available," says Mata. "Providers thought it was a very clunky process."

Different processes were used previously, depending on the time of day. "We added extra nursing coverage during the daytime to clinically screen all of our urgent admissions," says Mata. This change means there no longer are any surprises when patients show up in admitting. "Previously, some patients had urgent clinical needs that staff were unaware of," says Mata.

In some cases, a patient would be brought to the hospital's admitting department by ambulance, but no bed was available. "So the transport people would have to wait while we scrambled to find a bed for the patient," says Mata.

Another problem was that providers sometimes sent patients to the emergency department (ED), without realizing that an inpatient bed was available. "By having a better process upfront, we hope that providers will no longer send patients to an ED that can be directly admitted when we do have an open nursing unit bed upstairs," says Mata.

## Process: Internal transfers

Prior to the ITC, the previous transfer center was responsible for bringing in patients from other hospitals who needed a higher level of care.

"We were alerted to the fact that we needed a workflow in place for our internal transfers across multiple sites," says Mata. The centralized transfer center handles both types of transfers.

"Our nurses also handle the transfers from one building to another," says Mata. "They arrange the bed on the other unit and also arrange the transport through a contracted ambulance service."

Mata and her financial counseling team fall under the umbrella of patient access and work alongside the clinical side, which falls under the umbrella of nursing.

**Laurie McCullagh**, the ITC's administrative nurse, says, "We have a shared management of the department, and our staff are sitting side by side in the same department. As problems come to us, we work together to put together a comprehensive response."

In some cases, inpatients coming from other facilities are financially cleared first, but exceptions occasionally are made. Sometimes a physician would like to advocate for a patient and release a bed to an inpatient transfer despite lack of financial clearance. In this case, says Mata, "we have the option to secure an approval from the department chair for a physician override."

There is no Emergency Medical Treatment and Labor Act (EMTALA) risk with this process, she explains, because it pertains only to inpatient transfers. ED transfers do not go through financial clearance prior to releasing a bed. "As long as UCSF has capability to treat the patient and capacity, we accept the ED transfer and release a bed to the referring hospital," Mata says.

Transfers from the ED are financially cleared after the patients are brought in, in order to comply with EMTALA. "In the end, we do what's right for our patients. The clinical component will always trump the financial," says Mata.

Patient placement staff assist the transfer center nurses with medical/surgical placement; nursing staff place the ICU admits and transfers. "We troubleshoot problems across the medical center. It's not uncommon for us to get calls from the ED, the PACU [post-anesthesia care unit], and the recovery area," says Mata.

Nursing and financial counseling staff members are cross-trained to work in patient placement, transfer center, or handle urgent admit intake calls.

"When intake calls come in and they are trying to figure out the appropriate level of care, they work as a team to come up with the best plan," says McCullagh.

On any given day, there might be nine transfer patients and eight ED patients, all waiting for a bed. "The

## EXECUTIVE SUMMARY

Patient access and clinical units work together to financially and clinically clear transfer patients at UCSF Medical Center.

- A software tool allows patient access to see the status of available beds on the various units.
- Nurses work with the intensive care unit to prioritize patients.
- Providers no longer send patients to the ED who can be admitted directly when there is an available bed.

team figures out who goes first," Mata says.

For patients with a critical care diagnosis, the trauma center nurse works with the patient placement nurse to facilitate the transfer. In one case, says McCullagh, "when all the ICU beds were full, we arranged an ED patient to go straight to the neurological suite to have the procedure there."

### SOURCES


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# Fear dissatisfaction due to collections? Be an advocate for the patient

*Conversations 'can make a critical difference to someone's life'*

Patient access leaders at Chicago-based Presence Health have received "fewer and fewer" complaints from patients regarding the balance that they owe, reports **La'Queela Angel**, director of patient payments. One reason is that the hospital's Financial Assistance Committee routinely reviews accounts that didn't initially meet criteria for charity, to see if they qualify for an exception.

The hospital's policy states that patients with insurance don't qualify for charity unless they have an income that is 200% or below the federal poverty level (FPL). In some cases, Angel brings an account to the hospital's financial services committee and asks them to override the policy.

"We make the case for the patient," says Angel. "In some cases, they will approve it, and the patient qualifies for something less than 100% charity."

Patients are more satisfied because they don't receive a bill and because they receive assistance with their healthcare insurance needs. "They appreciate not having to go to the Medicaid office to complete an application," says Angel. "We in financial counseling can do that piece for them."

## Patients no longer billed

Charity is decreasing for Presence Health's self-pay patients, because many now qualify for some type of insurance under the Health Insurance Marketplace or for Medicaid. However, says Angel, "many of our self-pays who now have insurance still can't afford their coinsurance or deductibles."

Presence Health changed its processes to ensure that patients are screened for presumptive charity prior to being billed. "We run accounts through our eligibility systems to validate if the patient has any presumptive charity category," says Angel.

Financial counselors also do healthcare credit scoring to determine if the patient's income is at or under 200% of the FPL. If so, the patient qualifies for presumptive charity. "Instead of billing the patients, or having them fill out a complete financial assistance application, we know right away that they qualify," Angel says.

Before an account is sent to bad debt, one last check is done to be sure the patient's situation hasn't changed during the 120 days the account stays in accounts receivable. "You do have some patients that don't qualify initially, but later qualify because something has changed since they initially became a patient," Angel says.

If a patient didn't initially qualify for charity, he or she will start to receive statements. "But before they go to bad debt, we complete one last presumptive charity check for the patient account," says Angel.

If the result returns an account with a favorable FPL, the account is processed for presumptive charity, and the patient's bill never goes to bad debt.

"To hear the account has been


### EXECUTIVE SUMMARY

Point-of-service collections don't decrease satisfaction if registrars act as the patient's advocate, according to patient access leaders interviewed by *Hospital Access Management*.

- Determine if accounts qualify for an exception to charity policies.
- Offer options to insured patients who can't afford deductibles.
- Educate clinicians that patients have a right to make informed financial decisions.

adjusted to financial assistance makes the patient a very satisfied customer," says Angel.

## Be there for patients

A strong financial counseling process already was in place when patient access started point-of-service collections at OSF Saint Anthony Medical Center in Rockford, IL.

**Nicole Fountain**, CRCE-I, CHAM, revenue cycle director, says, "We knew very well that we had a safety net in place for people who couldn't afford to pay."

Fountain gets far more complaints about the billing process than the pre-service process. "Patients are much more disgruntled when they get a bill they don't expect than when you provide them information in advance, even when it's not good news," she explains.

Even if out-of-pocket costs come as a shock to patients, members of the staff are there to explain what options are available. "You are right there to help them through it," says Fountain. "That conversation can make a big difference to someone's life."

In some cases, patients are relieved to get enrolled with coverage for future healthcare needs. "It is really critical that you approach point-of-service collections as an advocate," Fountain emphasizes. *(See related story in this month's issue on how to educate clinicians on collections.)*

### SOURCES

- La'Queela Angel, Director, Patient Payments, Presence Health, Chicago. Email: LAngel@presencehealth.org.
- Nicole Fountain, CRCE-I, CHAM, Revenue Cycle Director, OSF Saint Anthony Medical Center, Rockford, IL. Email: Nicole.L.Fountain@osfhealthcare.org. ■

# Get registrars and clinicians on same page with collections

When patient access employees started point-of-service collections at OSF Saint Anthony Medical Center in Rockford, IL, complaints were "few and far between," says **Nicole Fountain**, CRCE-I, CHAM, revenue cycle director.

The complaints Fountain did receive came not from patients, but from her own employees. "If we could do it all over, we would have done a great deal more education for all of our employees, in all departments," she says.

Fountain was surprised to learn how many employees did not understand how their own insurance plan works. "We recommend starting there," she says.

Some employees felt strongly that collecting from patients didn't align with the hospital's mission. "In fact, some even suggested they would talk to our sisters about it — we are a Catholic facility — because they believed what we were doing was wrong," says Fountain. In reality, says Fountain, "the sisters fully support our point-of-service collection initiatives."

Many providers view financial issues as distinctly separate from clinical care and believe that it should not be discussed until care is completed. "We have even heard from providers who don't want us to discuss financial costs with patients because they might choose not have a service if they think they can't afford it," says Fountain.

## An informed decision

Fountain has made a point of educating registrars and caregivers about the patient's right to information, so they can make an informed decision.

"You wouldn't have surgery without knowing the clinical risks," says Fountain. "Patients deserve to know the financial risks, also."

If clinicians don't understand, they might take a dim view of collections and express this view to patients. "If your patients mention something to a caregiver about point-of-service collections, you might be surprised what that employee will say to the patient," says Fountain.

For this reason, Fountain recommends that patient access managers make sure that technicians, nurses, and physicians understand what the department is doing and why. "If they are acting as your advocates, you will be much more successful," she says. ■

## COMING IN FUTURE MONTHS

- Career ladders improve retention rates
- Foolproof ways to get most denials overturned
- Obtain new auths if patient's procedure changes
- How to challenge unrealistic payer requirements

# Patient attributes examined in provider electronic systems

More than a year ago, the National Association of Healthcare Access Management (NAHAM) offered recommendations recorded in the Office of the National Coordinator (ONC) for Health Information Technology's 2014 *Patient Identification and Matching Final Report. (To access, go to bit.ly/1lEL89E.)*

Pointing to a standardization of data attributes and their capture in electronic systems, the report says: "NAHAM supports continuing efforts to create an environment of positive patient identity and believes that the standardization of patient identification protocols and technologies are important means to this goal. NAHAM is investigating appropriate third factors to enhance positive patient identification. NAHAM supports the development of standards for data attributes in electronic systems, whether clinical or administrative, and enhanced common capabilities for all health data systems to input standardized data. …"

This reference to "appropriate third factors" is a call on providers to go beyond The Joint Commission's National Patient Safety Goal that at least two patient identifiers be used. While this requirement speaks primarily to the clinical setting, it is a benchmark for patient access as well, NAHAM says. NAHAM's recommendation calls for additional patient identifiers, ideally standardized in combination and means of collection, so that all healthcare systems are tracking the same data in the same manner, using the same recording protocols.

NAHAM's recommendations also included a call for standardized electronic health record (EHR) technology solutions that would support the standardized patient identification attributes: "Ongoing education and training are also important to ensure personnel at all levels understand the important roles patient data input and patient identification protocols serve in enhancing patient safety. NAHAM supports Stage 3 Meaningful Use requirements to improve patient matching and supports a comprehensive approach that includes the standardization of patient identification attributes, the development of standards for EHR technology solutions, and the development of best practices and protocols for data input. This would include regular feedback from supervisors and audits for quality control."

The same report recommended the following data attributes: first name, last name, previous last name, middle name or middle initial, suffix, date of birth, current address, historical addresses, current phone number, historical phone numbers, and gender.

Results of an informal NAHAM survey presented at the Patient Identity Integrity Symposium held before the Annual Educational Conference and Exposition showed that more than 80% of respondents collect the following information: name (first and last), home phone number, work phone number, date of birth, gender, next of kin, next of kin relationship, guarantor phone number, primary physician, insurance information, medical record number, and billing address. ■

HOSPITAL ACCESS MANAGEMENT™

HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

# Careful: HIPAA mental health change is limited, and not a free-for-all

President Obama's recent announcement that he is changing the Health Insurance Portability and Accountability Act (HIPAA) to allow reporting of patients with mental health issues drew acclaim from gun control advocates, but the effect on healthcare providers was not clear. Some legal experts caution that, despite how the rule change is being reported in the general media, it is not a broad HIPAA modification and will apply only to a subset of healthcare providers.

Don't let your physicians and staff misunderstand the rule change and think they have carte blanche to report patients whom they fear could be violent at some point. In most cases, that reporting still would be a HIPAA violation.

Most healthcare organizations don't report mentally ill patients to the Federal Bureau of Investigation's National Instant Criminal Background Check System (NICS), the federal database used to conduct background searches on people who want to buy guns. The database is intended to prevent guns from being sold to prohibited individuals, primarily felons, but also anyone deemed "mentally defective" or who has been involuntarily committed to a mental institution. The Justice Department reports that the database has prevented more than 2 million guns from getting into the wrong hands since it was created in 1998, with most of the data coming from state civil court systems.

> "THE WAY IT'S BEEN REPORTED IN THE MEDIA AND WHAT IT IS ARE ACTUALLY TWO DIFFERENT THINGS."

Previously, the Department of Health and Human Services didn't allow reporting to NICS under the HIPAA exemption when law enforcement agencies inquired about a person, even if the person posed a serious threat to health or safety. Some state agencies could report those individuals by separating patient healthcare information from other state data, but for the most part, the NICS received little such information. A 2012 General Accountability Office report stated that 17 states had submitted fewer than 10 records of people prohibited, for mental health reasons, from legally buying guns.

Intending to improve the reporting, the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) issued a final rule, which took effect this month. That rule clearly states that, for some covered entities, there is no HIPAA prohibition on reporting patients with mental health issues to the NICS. *(The rule is available online at http://tinyurl.com/h5526mc.)* The new rule states that HHS is modifying HIPAA "to expressly permit certain HIPAA covered entities to disclose to the National Instant Criminal Background Check System (NICS) the identities of individuals who are subject to a Federal 'mental health prohibitor' that disqualifies them from shipping, transporting, possessing, or receiving a firearm." Note that OCR addressed the change only to "certain" covered entities.

The rule also specifies some limitations: "Under this final rule, only covered entities with lawful authority to make the adjudications or commitment decisions that make individuals subject to the Federal

## EXECUTIVE SUMMARY

President Obama recently announced a change to the Health Insurance Portability and Accountability Act (HIPAA) that allows healthcare providers to report patients with mental health issues to a national criminal background database. The move is intended to prohibit gun sales to mentally ill people with a potential for violence.

- Some healthcare providers have debated whether HIPAA previously prohibited such reports.
- The rule change only affirms that a subset of healthcare providers can report patients with mental illness.
- HIPAA still prohibits most healthcare providers from reporting such concerns.

mental health prohibitor, or that serve as repositories of information for NICS reporting purposes, are permitted to disclose the information needed for these purposes. The disclosure is restricted to limited demographic and certain other information needed for NICS purposes. The rule specifically prohibits the disclosure of diagnostic or clinical information, from medical records or other sources, and any mental health information beyond the indication that the individual is subject to the Federal mental health prohibitor."

## Clarifying existing law

Essentially, OCR is affirming what already was the law under HIPAA, explains **Abner E. Weintraub**, a HIPAA consultant in Oregon City, OR.

HIPAA already allowed certain healthcare providers and the state agencies to report mental health issues to NICS without violating HIPAA, but the complexity of the law and the potential for substantial fines and other consequences caused many of them to hesitate and play it safe by deciding not to report, he explains. In the modified rule, OCR explains that those providers and agencies already had ways to report, but that they often required setting up separate entities and databases to keep information separate. That requirement was a burden and, as OCR describes, "despite these avenues for disclosure, many States still were not reporting to the NICS essential information on persons prohibited from possessing firearms for reasons related to mental health; concerns were raised that the HIPAA Privacy Rule's restrictions on covered entities' disclosures of PHI [protected health information] might be preventing certain States from reporting the relevant information to the NICS."

Healthcare providers can easily misinterpret the rule change, Weintraub cautions. The change — or more appropriately, the confirmation or clarification — applies only to state agencies or any other entity that is designated by a state to report information to the NICS. This group can include healthcare providers that operate within one of those agencies, such as state mental health facility.

"This is a very, very narrow change that affects a narrow group of providers. It does not affect 95% of healthcare providers, and it does not make any change to the requirements or prohibitions regarding health information for most medical providers," Weintraub says. "Because of the news reports going around, people think this affects all medical providers, but it does not. This is a huge misunderstanding in the making."

The healthcare providers most likely to fall under this part of HIPAA are those that have a contract to provide mental health assessments to courts, Weintraub explains. The new rule is an amendment to section 164.5 12 by adding a paragraph stating unequivocally that HIPAA does not prohibit those covered entities from disclosing PHI, he says.

"There has been a lot of discussion in that small circle that there is a conflict with HIPAA over the reporting that they have already been doing," Weintraub says. "OCR had been privately advising these folks that there is no conflict with HIPAA. But with gun violence in the news so much lately, OCR decided it was necessary to provide written clarification that HIPAA does not conflict with their ability to do this reporting."

## Most still can't release PHI

Other healthcare providers still are bound by HIPAA restrictions that prohibit the release of PHI, including a person's mental status.

That restriction means the typical acute care hospital still cannot report to NICS that a patient has a mental illness and could be violent, Weintraub explains. However, healthcare providers have always been allowed, even obligated, to report to law enforcement when patients pose a threat of imminent harm to themselves or others, he notes. HIPAA has never prohibited that reporting, and it still doesn't, Weintraub says.

"This was a clarifying change to a single section of HIPAA aimed at a very narrow segment of courts and agencies, and a very few medical providers involved with those courts and agencies, that were already allowed to report to NICS," he says.

Risk managers should be on the lookout for physicians and staff who misinterpret this HIPAA rule, says **R. Stephen Trosty**, JD, MHA, ARM, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

"The way it's been reported in the media and what it is are actually two different things. It's very confusing," Trosty says. "I hope risk managers will look into the actual regulation and not just go on what the media reports. They will find that, in most cases, it doesn't affect them and nothing has changed."

Trosty is more concerned about physicians. If they are removed from the hospital's education pipeline, where the risk manager should educate staff about what the rule change means, physicians and their practice staff might rely on media reports that give the impression that they can report patients with mental issues, he says. Many physician offices don't keep up with HIPAA details on a day-to-day basis, he notes.

"Given what's been happening with the shootings lately, all the concern over that, they may decide that it's better to be safe than sorry. They want to do the right thing, so they try to report the patient to the database," Trosty says. "Of course, that's going to get them in trouble."

Risk managers should ensure that education about the HIPAA rule includes not just hospital staff but also physicians and their staffs who are affiliated with the hospital or health system, Trosty advises. Too often, he says, physicians are left out of the loop when risk managers provide education.

"The liability is going to be on the hospital or health system if the physicians in that system do something wrong," Trosty says. "This is a potential liability issue that can have very substantial financial consequences."

### SOURCES


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- **Abner E. Weintraub**, Oregon City, OR. Telephone: (503) 759-311. ■


# Data analysis reveals most common HIPAA violators

Several large pharmacy chains and health systems are among the most frequent violators of the Health Insurance Portability and Accountability Act (HIPAA), according to a recent report from ProPublica.

Among healthcare providers nationwide that repeatedly violated HIPAA between 2011 and 2014, some of the top offenders were the following:

- Department of Veterans Affairs;
- CVS;
- Walgreens;
- Kaiser Permanente;
- Wal-Mart.

Interestingly, however, these repeat offenders were not punished by the Department of Health and Human Services (HHS) Office for Civil Rights (OCR).

ProPublica, which describes itself as an independent, non-profit newsroom that produces investigative journalism in the public interest, found that in more than 200 instances of HIPAA violations during those four years, OCR only reminded CVS of its obligations under the law or accepted its pledges to improve privacy protections. ProPublica acknowledges that the organizations with the most HIPAA violations are all large healthcare providers with many locations that serve millions of patients each year, increasing the likelihood of HIPAA violations. ProPublica counted as violations those complaints that resulted in corrective-action plans submitted by a health provider or "technical assistance" provided by the Office for Civil Rights on how to comply with the law.

Offenses by the top violator, the Department of Veterans Affairs, included incidents of employees accessing patient files of co-workers and patients they were not treating.

ProPublica reports that one employee accessed her ex-husband's medical record more than 260 times, while another accessed the records of a patient 61 times and posted details on Facebook. A third provided a patient's health information to his parole officer, ProPublica reports.

ProPublica also is using the HIPAA violation data to launch a new tool called HIPAA Helper, which allows searching for reports of privacy violations by provider, which is apparently the first such resource offered to the public. *(HIPAA Helper can be accessed at https://projects.propublica.org/hipaa. The full ProPublica report is available online at http://tinyurl.com/gu2vfep.)* ■

# HHS offers guidance to patients on accessing their protected health information

Responding to complaints that the Health Insurance Portability and Accountability Act (HIPAA) sometimes makes it difficult for patients to obtain their own medical records, the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) recently issued guidance to help people better exercise their existing rights for accessing that information. The guidance also might prove useful to healthcare providers when patients make unreasonable demands for information.

HIPAA always has allowed patients to access and obtain a copy of their personal health information under the HIPAA Privacy Rule, explains OCR Director **Jocelyn Samuels** in a blog post announcing the guidelines. *(Her blog is available online at http://tinyurl.com/gptzh6m.)*

Samuels says the guidance explains the scope of information covered by HIPAA's access right; the narrow exceptions to the right and other mandated elements, including timeliness; the form and format for providing access; and how the HIPAA access right intersects with patient access requirements under the electronic health record meaningful use and incentive program.

"The HIPAA Privacy Rule has always provided individuals with the right to access and receive a copy of their health information from their doctors, hospitals and health insurance plans," Samuels writes in her blog. "Unfortunately, based on recent studies and our own enforcement experience, far too often individuals face obstacles to accessing their health information, even from entities required to comply with the HIPAA Privacy Rule. This must change."

Samuels announced the release of a fact sheet and the first in a series of topical Frequently Asked Questions (FAQs) to further clarify individuals' right under HIPAA to access and obtain a copy of their health information. The set of FAQs addresses the scope of information covered by HIPAA's access right, the very limited exceptions to this right, the form and format in which information is provided to individuals, the requirement to provide access to individuals in a timely manner, and the intersection of HIPAA's right of access with the requirements for patient access under the HITECH Act's Electronic Health Record (EHR) Incentive Program.

> THE GUIDANCE ALSO MIGHT PROVE USEFUL TO HEALTHCARE PROVIDERS WHEN PATIENTS MAKE UNREASONABLE DEMANDS FOR INFORMATION.

A key explanation in the guidance addresses how individuals have a right to access protected health information (PHI) in a "designated record set." It also delineates the limits of what healthcare providers are required to provide. OCR explains that a designated record set is defined at 45 CFR 164.501 as a group of records maintained by or for a covered entity that includes these documents:

- medical records and billing records about individuals maintained by or for a covered healthcare provider;
- enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan;
- or other records that are used, in whole or in part, by or for the covered entity to make decisions about individuals. This last category includes records that are used to make decisions about any individuals, whether or not the records have been used to make a decision about the particular individual requesting access.

"Thus, individuals have a right to a broad array of health information about themselves maintained by or for covered entities, including: medical records; billing and payment records; insurance information; clinical laboratory test results; medical images, such as X-rays; wellness and disease management program files; and clinical case notes; among other information used to make decisions about individuals," the guidance notes. "In responding to a request for access, a covered entity is not, however, required to create new information, such as explanatory materials or analyses, that does not already exist in the designated record set."

The OCR fact sheet and FAQs are available online at http://tinyurl.com/gsu7zao. ■

# Texas Health Resources Insurance Verification Precertification Turn Around Times For High Tech Radiology Procedures

| Insurance | Auth turnaround time for High Tech Radiology Approval |
|---|---|
| **Payor A** | Same day or up to 3 days |
| **Payor B** | Up to 7 days |
| **Payor C** | Same day or up to 3 days |
| **Payor D** | 3 to 14 days |
| **Payor E** | Same day or up to 3 days |
| **Payor E** | 72 hour maximum |
| **Payor F** | Case by case since payer is  out of network |
| **Payor G** | Case by case since payer is out of network |
| **Payor H** | Same day or up to 3 days maximum |
| **Payor I** | 24 Hours |