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Patients Expect 'Self-service' Registration Capabilities

However, be careful to avoid delivering an outdated experience

Self-registration kiosks have been in place for three years at Moffitt Cancer Center in Tampa, FL, but their time is short-lived. The department is moving to a new phase of "self-service."

"We'll be decommissioning the kiosks soon in favor of a more hands-on, 'fast track' registration process while we develop our next generation of self-service technology," Patient Access Director **Lynne Hildreth** says.

Patient access employees, not the kiosks, were verifying patients' identities and placing armbands.

"As a result, we weren't creating a quicker registration process for patients, nor were we reducing our labor expense," Hildreth says.

The kiosks filled a considerable amount of space in the department and created a bottleneck instead of improving registration.

"WE ARE PLANNING TO ADJUST OUR STRATEGY, AND IMPLEMENT A SELF-SERVICE REGISTRATION OPPORTUNITY." — LYNNE HILDRETH, MOFFITT CANCER CENTER

"The kiosk technology was quick to become dated and obsolete," Hildreth says. "We are planning to adjust our strategy and implement a self-service registration opportunity."

Instead of using the kiosk after arrival, patients will register at home or on a mobile device. "We have seen several vendors who are enabling this process by producing a 'boarding pass,' which the patient would present upon arrival," Hildreth says.

The patient would then obtain an armband and be taken quickly to their appointment.

"We're particularly excited about coupling this into the appointment reminder process," Hildreth says.

Patient access plans to give patients the ability to complete questionnaires and forms in advance and to receive tailored pre-visit information.

"We feel very confident that this

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will be well-received by our patients, who have high engagement with our patient portal today," Hildreth says.

More than 75% of new patients complete a questionnaire online before their first visit. "Established patients visit the portal more than twice a month on average," Hildreth says.

What's the Holdup?

Patient access is undergoing a shift to self-service that goes beyond just pre-registration. "The new 'patient experience' in a digital world should be looked at more holistically, in all forms, from scheduling through dismissal," says **John Woerly**, RHIA, CHAM, FHAM, principal director of Accenture Health Practice in Indianapolis.

Patients hope the registration process will rival the customer service provided by other industries. "Despite revolutionary technologies in the retail marketplace — airlines, hotels, banking — healthcare is, for the most part, at the beginning stages of development," Woerly says.

Few patient access departments offer online pre-registration, Woerly notes. Those that do often have small numbers of patients participating. "It still requires printing the patient's data from the online entry, then re-entering the data into the system," Woerly explains.

Patient access has to move into the digital world to earn patients' loyalty. "To do so, they will have to venture far beyond the traditional realms of clinical care, customer service, and hospitality," Woerly says.

Successful patient access departments will view patients who register as customers.

"Up until now, hospitals have been focused on efficiency," Woerly says. "To be effective, hospitals need to give memorable service experiences."

Mobile Tech Is Driver

Ryan Stutzman, product manager for patient self-scheduling at Medfusion, a Cary, NC-based healthcare IT company, says, "In the near future, we will see patients taking a much more active role in all aspects of their healthcare. Mobile technology will be a key driver."

Five years from now, he predicts, registrars will know when a patient has arrived and collect payments — all from the patient's mobile device. "This will happen without ever calling a name, collecting a form, or swiping a credit card," Stutzman says.

Ironically, one of the main obstacles to "self-service" in patient access is the sheer number of technology

EXECUTIVE SUMMARY

Patient access departments are moving from self-registration kiosks to a broader focus on self-service technology, with patients pre-registering, paying balances, and completing forms on mobile devices. Some considerations:

- Kiosks still require employees to verify patients' identities and place armbands.
- Lack of integration is a significant obstacle.
- Pre-registration conducted via patient portals sometimes requires re-entering data.

solutions available.

"Many front-desk administrators see each new popular tech tool as just another system to manage, screen to log on to, or thing that can break," Stutzman explains.

Solutions don't "talk" to one another. "Once the problem of interoperability is solved, we will see mobile technology transform healthcare, in the same way it has almost every other industry," Stutzman says. ■

SOURCE

- **John Woerly**, RHIA, CHAM, FHAM, Principal Director, Accenture Health Practice, Indianapolis. Email: John.woerly@accenture.com.

Is Patient Access Staff Absent from Certain Hospital Committees?

Department should not be without a voice in critical decision-making

A few years ago, Stamford (CT) Hospital's IT department and physician leaders carefully planned a new process to scan consent forms automatically into the hospital's electronic medical record (EMR). They made the mistake of not asking patient access for input.

"What they didn't realize was that we were still doing the consents, even though they were being scanned into the system," Patient Access Director **John Hegarty** recalls.

Also, patient access terminals weren't connected to the printers, so documents were not arriving at the appropriate destinations. "By not including us, everything got put on hold while we figured out the workflow," Hegarty says. "It got worked out pretty quickly, but it was ugly."

The needless glitches made a strong impression. "Now, anytime this committee wants to make a change, they first ask, 'What's it going to do to the front end?'" Hegarty says, noting that a specific IT employee partnered with patient access to keep the department apprised of planned changes. "If anything comes up in the IT world, we have someone who will give us a heads up."

Even seemingly minor changes can wreak havoc on productivity if the facility overlooks patient access, Hegarty warns. If a mistake is made in other departments, it typically affects just that visit, he says. "But mistakes made by patient access send ripples throughout the entire organization, regardless of the department the patient is having their service in," Hegarty says. "That is why patient access is the most important department, in my view." Here are some hospital committees in which patient access can participate:

• **Finance**. Monthly meetings with the hospital's finance committee allow Hegarty to drive home an important point: Registration quality matters.

"We look at other pieces of the revenue cycle to see what we can do better on the front end to decrease the work that needs be done on the back end," he says.

Recently, patient access invested in price estimation software. Registrars now offer self-pay discounts and set up patients on payment plans. "I have very clear expectations from the CFO, who holds patient access in very high regard, as to what we need to be monitoring," Hegarty adds.

• **Regulations**. At Stamford Hospital, this committee recently focused on two big changes that directly affect patient access: the state's "surprise medical bill" legislation and federal 501(r) regulations on financial counseling. "Patient access is very important from a compliance standpoint," Hegarty emphasizes.

• **Privacy**. Protecting patients' privacy "all starts with us in patient access — how we obtain information, talk to patients, and stay in compliance," Hegarty says.

• **Patient satisfaction**. Hegarty is involved in multiple patient satisfaction committees throughout the hospital. "You name the department that has a steering committee for pa-

EXECUTIVE SUMMARY

Patient access representation on hospital committees can avoid problems during system conversions or process changes throughout the organization. Some examples:

- Patient access can get feedback from finance on which metrics to monitor.
- Patient access can help the organization comply with new legislation and regulations.
- Patient access can train employees in standardized patient identification processes.

tient satisfaction — surgery, dietary, the Breast Center — and I'm on it," he says.

Arguably, patient access plays perhaps the most important role in the entire hospital, in terms of overall patient satisfaction. "The experience starts with us," Hegarty says. "If the patient has a negative experience walking in the door, it's hard to get them back."

The goal for registrars is to either give patients a "wow" experience, or have patients not recall the registrar at all. "It's great if they don't even remember what they did with you," Hegarty says. "That means the experience on the front end was as smooth as possible."

• **System conversions**. **Maria Lopes-Tyburczy**, director of patient access at Hackensack UMC Palisades, North Bergen, NJ, says, "Patient access will be using the system. The more they are involved in the conversion, the more efficient and successful the 'go-live' date."

Patient access staff know what fields are neccessary to capture required information, such as race and ethnicity, birth place, and preferred language. "There are multiple fields that need to be tested thoroughly to ensure accuracy," Lopes-Tyburczy stresses.

Stamford Hospital is planning a system conversion, and while it's early in the process, it's not too early for patient access to have a say. "As we look to move to a different system down the road, patient access is involved in vendor presentations and demos right from the beginning," Hegarty explains.

• **Patient safety**. "Anytime there is a patient safety issue, they bring in patient access," Hegarty notes. Sometimes, an adverse event can be traced back to a front-end process. For example, if a patient was misidentified, patient access can identify if there were any gaps in the process. This is less likely to occur if the hospital standardized patient identification processes.

"Previously, there was not one clean, consistent way to identify a patient within the system," Hegarty recalls. "Departments were doing things their own way." Recently, patient access worked with the hospital's health information management department to train 400 employees on how to correctly identify patients.

Patient Access Feedback Prevented Problems

At Saint Francis Hospital – Bartlett (TN), patient access leaders and high-performing employees participate on multiple committees. These include regulatory compliance, the privacy incident response team, hospital throughput, outpatient growth, revenue cycle, Cerner process improvement, quality, and employee engagement.

Patient Access Director **Angela D. Jordan**, CHAA, CRCR, estimates that patient access affects 75% of processes throughout the facility. "We use these committees to expose and mentor staff on how our processes affect the big picture," she says. Here are two problems that were avoided, due to feedback offered by patient access:

• **During a recent meeting of the hospital transfer committee, no one mentioned anything about how the patient's insurance would be verified**. Without verifying insurance, there would be no way to ensure the hospital was in network. When Jordan brought it up, a committee member replied, "We never thought about that."

"We immediately resolved the process by incorporating validation to ensure reimbursement," Jordan recalls. The department also implemented a system to notify users of errors in real-time.

"This system combines multiple systems already used by patient access to accomplish a one-stop view of potential registration errors," Jordan explains. "This supports clean billing and faster reimbursement."

• **Recently, patient access was asked to expand its hours to accommodate the physicians' end-of-the-day patients and direct admits**. Otherwise, the patient would have to register in the ED for services, which could mean a longer wait.

"Patient access supports initiatives to better serve patients," Jordan says. "We reviewed current schedules and cross-trained employees."

First, patient access reviewed the volume during the requested hours. It also reviewed volume at patient access entry points during peak times.

"We accommodated the request by reallocating resources," Jordan explains, noting patient access employees were cross-trained to register patients at all entry points. "The cross-training included entering in the correct clinic codes, touring the area, and the authorization process." ■

SOURCE

- **Angela D Jordan**, CHAA, CRCR, Director, Patient Access, Saint Francis Hospital – Bartlett (TN). Phone: (901) 820-7755. Email: angela.jordan@coniferhealth.com.

"We are considered the system experts," Hegarty adds.

If patient access doesn't identify the patient correctly in the system, says Lopes-Tyburczy, a lot of negative outcomes can come from this. On the patient safety committee, patient access alerted other departments to some of the challenges associated with properly identifying patients. "Patients may come in unresponsive, give a fake name, or give misspelled names or nicknames," Lopes-Tyburczy says.

• **Patient throughput**. At times, decisions are made on how ancillary departments should operate without involving patient access. "Patient access needs to be involved in these decisions, so that the ancillary departments can operate efficiently," Lopes-Tyburczy says.

Patient access must be included when metrics are set for door-to-discharge, or door-to-inpatient status, for instance. "We need to ensure all demographic and insurance information is obtained timely, so the continuum of care is not disrupted," Lopes-Tyburczy adds. ■

SOURCES

- **John Hegarty**, Director, Patient Access, Stamford (CT) Hospital. Email: JHegarty@stamhealth.org.
- **Maria Lopes-Tyburczy**, Director, Patient Access, Hackensack UMC Palisades, North Bergen, NJ. Phone: (201) 295-4028. Email: mlopes-tyburczy@palisadesmedical.org.

Meet 99.9% Accuracy Goal, Watch Denials Plummet

Patient access focuses on "clean claim" metric

The "clean claim" metric — the number of claims sent without errors causing denials — is extremely important to the overall revenue cycle, says **Nancy Diamantopoulos**, director of patient access at Steward Holy Family Hospital in Methuen, MA.

"Patient access is essential in the clean claims process," she adds.

Steward Holy Family's patient access department works daily with the hospital's central business office to ensure claims bill out "clean" and are paid timely.

"These meetings are extremely productive in reviewing our claims errors," Diamantopoulos says.

The department recently implemented a process to ensure all authorizations and referrals are obtained prior to the patient visit.

"This eliminates the 'dirty claim' and denials," Diamantopoulos notes.

As director of patient accounting at Norfolk, VA-based Sentara Healthcare's Central Business Office, **Brenda Loper** struggled for years to find a way to reduce registration errors causing claims denials.

"When I moved to the front end and assumed responsibility for access services, I was determined to find an answer," says Loper, now director of patient access at four Sentara Healthcare hospitals.

Loper found that nearly all front-end errors stemmed from these two problems:

• inadequate staff education, and

• failing to provide employees with the tools needed to get it right the first time.

"As I told our staff in patient accounting, registration staff do not get up in the morning and say to themselves, 'I am going to make 16 errors today. That is my goal,'" Loper explains.

The department's goal is 99.9% accuracy on all registrations.

"Nearly all of our facilities are meeting or exceeding this goal now," Loper says.

ID Reason for Denial

Sentara Healthcare's patient accounting department sends a weekly claims denial report to patient access. Every account that was denied on re-

EXECUTIVE SUMMARY

Patient access departments are improving the "clean claim" metric to decrease claims denials. Some successful approaches:

• Obtain authorizations and referrals before the patient arrives.

• Use registration accuracy and eligibility software to confirm coverage and improve accuracy.

• Review accounts that were denied to see if staff followed the proper procedure.

mittances the previous week is listed.

"Specific codes clearly show the reason for the denials," Loper says.

Patient access focuses on these four types of denials:

- The claim was adjusted because the care may be covered by another payer per coordination of benefits;
- Expenses were incurred before the coverage took effect, during a lapse in coverage, or after the patient's coverage was terminated;
- The claim was denied because the patient cannot be identified as the insured;
- Services were not covered because the patient is enrolled in a hospice.

"The manager of access in each of our facilities reviews the accounts to determine if staff followed the correct procedure," Loper says.

For instance, an employee might not have launched the eligibility software or may have attached the incorrect insurance to the record.

The manager meets with each employee to review errors and determine why they occurred.

"The first step is to determine if there was a reason beyond their control, such as system downtime preventing the eligibility launch," Loper says.

Once this is ruled out, the employee and manager discuss the errors made. Together, they figure out what should have happened.

"Once this has been done, if errors continue to occur, they are dealt with based on department policy," Loper says. *(See sidebar at left to learn how patient access uses technology to reduce errors.)* ■

Evolving Regs Demand Right Technology

As soon as registrars get comfortable with a certain payer or regulatory requirement, they can count on it to change.

"Or new ones will be created," **Brenda Loper** says. "The key to thriving in this world of change is having the right technology." The patient access department recently implemented these solutions:

• Supervisors use registration accuracy software to give feedback to staff while they are completing a registration.

"We have compared it to having a supervisor standing behind each employee and gently tapping them on the shoulder when they make a mistake," Loper says, adding that registrars and managers receive daily feedback on uncorrected errors. "A very practical benefit of this product is our ability to create new rules whenever we need them."

When the department learns of a change in payer requirements, Loper says, "we contact our internal support person and discuss the change needed."

She looks at what the system can support, and then builds rules to detect errors. For instance, the hospital is contracted with two of the three carriers in the state who offer Coordinated Care Plans, a combination of Medicare and Medicaid coverage. The uncontracted carrier will only pay for emergency services.

"A rule was created to fire off an error message based on the insurance plan code created for this carrier," Loper says.

Another rule was set up to flag any account that is set up with Medicare Part B as the primary financial class. This should be used only if the patient does not have Part A benefits.

"In that rare occasion where Part B is correct, the error is disputed with an explanation," Loper adds.

• Registrars use eligibility software to confirm patients' coverage.

Scheduled patients are handled by a centralized pre-registration department. "So that has never been an issue," Loper says. "Walk-in patients present the greatest challenge for ensuring they have coverage for services."

This is true for both the ED and outpatient services. For these patients, the department relies heavily on eligibility confirmation software to be sure the information provided at the time of service is accurate. This also gives patient access the chance to collect copays.

"We recently changed the eligibility vendor we were using. One immediate result was the elimination of employees 'forgetting' to launch a query," Loper says.

The new software does it automatically, and it can't be bypassed. It hasn't been operational long enough to produce meaningful reports on claims denials yet, but Loper is very optimistic.

"I'm excited to see how the reports coming from patient accounting will be impacted by this change," she says. ■

SOURCES

- **Nancy Diamantopoulos**, Director, Patient Access, Holy Family Hospital, Methuen, MA. Phone: (978) 687-0156, ext. 2426. Email: nancy.diamantopoulos@steward.org.
- **Brenda Loper**, Director, Patient Access, Sentara Healthcare, Norfolk, VA. Email: bcloper@sentara.com.

ED Registration Processes Can Trigger Litigation Against Hospital

Registrars' involvement in clinical decisions is legal land mine

A combination of laws, economics, and insurance trends leads to an increase in patient complaints — and sometimes lawsuits — relating to ED and trauma care, says **Robert J. Milligan**, JD, an attorney at Milligan Lawless in Phoenix.

"Most insurers refuse to pay a premium to specialist physicians who are willing to provide call coverage for EDs," Milligan notes.

The physicians who provide this coverage are required to take all comers, many of whom don't have insurance.

If specialists who are called in to see a patient are out of network with the patient's insurer, it leaves the patient with little or no coverage. This results in an unpleasant surprise when the patient receives a bill for out-of-pocket responsibility.

"Often, physicians refuse to contract with insurers that pay the same rates for elective office services and for services provided at midnight on Christmas Eve," Milligan explains.

Insurance Not Discussed

The hospital could face legal liability if staff inquire about insurance or ability to pay in a way that is prohibited under the Emergency Medical Treatment and Labor Act (EMTALA), Milligan warns.

This limits the ability of patient access to ask about a patient's insurance status. Also, trauma patients often are in no condition to discuss insurance, regardless of EMTALA limitations.

"As a result, there typically is no discussion about insurance or whether the specialist on call is contracted with the patient's insurer — until after the specialist provides the necessary care," Milligan says.

Since patients typically pay a larger share of their healthcare bills for treatment received by an out-of-network provider, this often results in surprised and unhappy patients.

"Some of these patients simply refuse to pay the bills; others make complaints to the relevant licensing agencies, and others air their grievances with the media," Milligan says.

It's possible that meaningful discussions between insurers, hospitals, and specialists might lead to an improvement in this situation, Milligan offers.

"I am not aware of any situations in which those discussions have led to a solution, however," he adds.

Out-of-Pocket Costs

Keith C. Volpi, JD, an attorney at Polsinelli in Kansas City, MO, has defended several lawsuits regarding the activation of a hospital trauma protocol.

"This decision most commonly is forced when a first responder calls the hospital to report that an ambulance is en route with a patient with particular injuries," Volpi says.

Patients often find out that they are responsible for large medical bills. "The patients are upset that the trauma protocol was 'unnecessarily' activated," Volpi explains.

Volpi also has defended the other side: A patient was critically injured in a car accident, and the trauma protocol was not activated. When the patient arrived, he had to wait for critical services and personnel to mobilize, and he claimed that his injuries worsened as a result. "Medical negligence was the allegation, which provided the patient the same opportunity for recovery as in any other medical negligence action," Volpi says.

Volpi notes it's important that the policy or algorithm dictating the decision of whether to activate the trauma protocol is clear and understood by all who may be called to use it.

EXECUTIVE SUMMARY

The ED registration process can result in litigation against the hospital due to lack of compliance with EMTALA, or, on the other hand, out-of-pocket expenses the patient alleges were avoidable.

- Patients often are surprised by large medical bills due to activation of trauma protocols.
- On-call specialists may be out of the patient's insurance network.
- Registrars must be EMTALA-compliant when asking about insurance or ability to pay.

"Additionally, it is important that individuals with clinical expertise, as opposed to clerical personnel, are responsible for making all decisions that could possibly be viewed as clinical," Volpi says.

This includes the decision of whether to activate the trauma protocol. "It also includes something as simple as discussing what brings a patient into the ED," Volpi adds.

Registrars must be careful to not become involved in any such clinical decisions.

"An administrative person making clinical decisions is low-hanging fruit for any good plaintiffs' attorney," Volpi warns. ■

SOURCES

- **Robert J. Milligan**, JD, Milligan Lawless, Phoenix. Phone: (602) 792-3501. Fax: (602) 792-3525. Email: Bob@milliganlawless.com.
- **Keith C. Volpi**, JD, Polsinelli, Kansas City, MO. Phone: (816) 395-0663. Fax: (816) 817-0210. Email: kvolpi@polsinelli.com.

Payers Want Up to 14 Days to Review Authorization Requests

Timeframe is "huge challenge" for financial clearance

Payers want up to 14 days to review a simple authorization request. Meanwhile, physicians want to schedule patients ASAP. Patient access is caught in the middle.

"Of course we want all our patients to be able to come in as planned. But sometimes we can't reach a point of financial clearance," says **Joseph Ianelli**, director of patient financial services at Massachusetts General Hospital in Boston.

If the payer won't give the authorization in the timeframe the physician wants, Ianelli says, "there are a number of different things we have to think about."

One is the high frustration level of clinicians, who don't understand why their patient can't be scheduled as planned.

"We explain what the process is, and why we can't move forward," Ianelli adds.

Kim Rice, MHA, patient access director at Shasta Regional Medical Center in Redding, CA, sees payers scrutinizing more details on authorization requests. "We must keep up to date on the requirements and expectations," she says.

Securing financial approval sometimes means getting on the phone, which is time-consuming. "Certain payers, such as Blue Cross, can take over an hour to just get through to speak to the representative," Rice notes.

Urgent Need Conveyed

Patient access sometimes contacts payers and conveys the urgent need for the approval, with mixed results.

"In my experience, the payers want to help out. Most payers are willing to do their best to process the auth sooner," Rice says.

Sometimes, payers bring an honest mistake to the attention of patient access, such as incorrect or missing CPT codes.

Ashley Walker, patient access authorization supervisor at four Health First hospitals in northeast Florida, says most commercial payers give a response within 24 hours if the authorization is not approved automatically.

"Some payers require that a physician signature be submitted if patient access is requesting an expedited review," Walker says.

Once the request is received, it's processed within three business days.

The hospital's central scheduling team verifies the patient's insurance when booking the appointment, taking timeframes into account.

"They push the appointment out according to the health plan's authorization processing time frames," Walker explains.

For instance, if a patient presents with Aetna insurance, the appointment is scheduled five business days out, but if the patient presents with

EXECUTIVE SUMMARY

Payers are requiring up to 10 days to review authorization requests, putting patient access in the position of possibly rescheduling patients if accounts can't be financially cleared. Patient access can:

- explain the process to clinicians to reduce frustration;
- ask higher-ups to determine if the patient can be scheduled without the authorization in place;
- ask payers to expedite the process, if possible.

Medicaid, it's scheduled for 14 days out.

"This gives our team enough time to process the authorization," Walker says. If the team is unable to obtain the authorization in time, they inform centralized scheduling to either cancel or reschedule the appointment. Patients are informed this is a possibility. *(See related stories at right and below on payer contracts and the rescheduling process.)*

"Our auth team also picks up the phone and calls the specific payer to make sure that they're aware the appointment is an ASAP or STAT," Walker says. "This hopefully speeds up the review process." ■

SOURCES

- **Joseph Ianelli**, MGH, Director, Patient Financial Services, Massachusetts General Hospital, Boston. Email: jianelli@partners.org.
- **Kim Rice**, MHA, Director, Patient Access, Shasta Regional Medical Center, Redding, CA. Phone: (530) 229-2944. Fax: (530) 244-5185. Email: krice@primehealthcare.com.
- **Ashley Walker**, Patient Access Authorization Supervisor, Health First, Rockledge, FL. Phone: (321) 434-5459. Fax: (321) 434-5420. Email: Ashley.Walker@health-first.org.

Reschedule Elective Procedures as Last Resort

If no authorization is in place for a truly elective service, with no adverse consequences for the patient, it's rescheduled, but patient access avoids using that word at Massachusetts General Hospital. "We use the word 'postponing.' That gives the patient hope that we can get to a place of 'yes,'" **Joseph Ianelli** says.

Sometimes, a clinician simply wants to put a patient in an opening in the schedule. If there is a medical reason why the service needs to be performed earlier, an escalation process occurs. In these cases, Ianelli says, "we get the front-line people out of the decision-making." The hospital's chief medical officer makes the final decision as to whether the hospital is going to take the financial risk of scheduling the patient without the authorization in place.

To keep such situations to an absolute minimum, patient access starts the process two weeks in advance. "If we work too far out, the patient's insurance could change," Ianelli explains. Any sooner, though, and payer time frames aren't met. That means the service might need to be rescheduled on short notice, something patient access tries to avoid at all costs.

"Nobody should have to call a patient one day before to reschedule, when it's been booked for a month," Ianelli says. At Shasta Regional Medical Center, the five business days required by most payers is a "huge challenge for the financial counselors who vet the account for financial clearance," **Kim Rice** says.

If the patient access team doesn't receive an authorization by the day before the patient's scheduled service, they ask the office to reschedule. "It is rare that we have to do this. But my team is looking out for the facility's and patient's best interest. We do not want a denial," Rice says.

Monique Williams, manager of patient financial services at Montefiore Health System, says payers are requiring between three and 14 days to approve authorizations. "Some health plans recently changed their policy to only provide authorization the day before a patient is set to arrive," she adds. For all cases in which the procedure is not authorized 72 hours prior to arrival, patient access notifies the department that the patient is missing an authorization. They specify what time frame the health plan allows to obtain it.

"If there is no time to obtain authorization by scheduled surgery date, the physician is contacted, and a new date is determined," Williams says. ■

Identify Unrealistic, Problematic Wording in Payer Contracts

Patient access is in best position to pinpoint problems

Patient access should be familiar with its facilities' third-party contractual agreements and make sure they don't include provisions that will cause problems, urges **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Healthcare in Atlanta.

"The more cynical among us suspect that insurance companies push hard to include contractual provisions that are difficult for the provider to avoid, or at least delay, payment," Kraus says.

Easily Identifiable?

It is important that contract-related claims payment requirements appear on the insurance ID card so they can be identified accurately, Kraus says.

"The requirements themselves must be manageable by patient access staff, within a time frame compatible with the scheduling/preadmit/admit process flow of the institution," Kraus adds, recommending staff ask these questions:

- **If there are follow-up requirements, are they easily identifiable and doable within a reasonable time frame?**
- **Are parameters for payer response compatible with patient care expectations?**

"Access must be clear on what department is responsible for follow-up and, if necessary, have trained staff available whenever required," Kraus says.

- **Are any "silent" preferred provider organizations involved? If so, do they apply to all admissions, or only certain diagnoses or procedures?**
- **Does the payer stipulate contractual rules about what can be collected from a patient prior to service?**
- **How are exceptions addressed?**
- **Is there a provision for situations in which information isn't available in a timely manner from the patient or internal/external systems?**
- **What if a patient access staff member makes an unintentional error? Can the problem be fixed retrospectively if caught within a reasonable time span?**
- **Are payer and facility on the same page if a prospective patient fails to meet contractual criteria and challenges the denial of coverage?**

"All these variables and many others can be hidden or obfuscated in contractual language," Kraus notes.

Ideally, the facility should standardize contractual language and provisions for all payer contracts. This way, patient access has to learn just one set of rules.

"At a minimum, the language should be sufficiently similar and stated clearly enough to avoid obscure provisions and variances not discovered until the payer denies a claim," Kraus says, recommending patient access work closely with the facility's contract management team on this. "The biggest problems tend to relate to unreasonable data requirements, timing issues, inflexibility, and language ambiguity." Kraus recommends these practices:

"AT A MINIMUM, THE LANGUAGE SHOULD BE SUFFICIENTLY SIMILAR AND STATED CLEARLY ENOUGH TO AVOID OBSCURE PROVISIONS AND VARIANCES NOT DISCOVERED UNTIL THE PAYER DENIES A CLAIM," KRAUS SAYS.

- **Create a collaborative arrangement with the facility's managed care department**.

This allows patient access leaders to provide input to prevent contracts from containing clauses that are difficult, time-consuming, or outright impossible to meet.

Providers should reject provisions that are not in their interest, if at all possible, Kraus argues, and address those that prove unavoidable.

"Examples might include when the facility is required to notify the payer prior to or during the patient's treatment, or provide information prior to admission that is unlikely to be available at that time," Kraus says.

- **Encourage managed care to negotiate similar prerequisite provisions for all payers**.

Even if reminder prompts to users are programmed into the registration system, Kraus says, "the fewer differences among payers, the better. This minimizes hard-to-remember exceptions to the rule."

Encouraging a standardized approach across payers "avoids at least some unexpected 'gotchas,'" Kraus adds. ■

SOURCE

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Auth-related Denials Are Major Focus; More Full-time Employees Needed

Patient access seeing "marked increase" in denied claims

Authorization-related denials are a major focus at Chesapeake (VA) Regional Healthcare, reports Patient Access Director **Melissa A. Salyer**, CRCR.

A pre-registration authorization team has been in place for several years.

"This team has increased in FTEs over the last year, simply to keep up with the changing demands of authorization requirements by the payers," Salyer says.

The team offers authorization services to physician offices for various service lines. These include MRI, CT, ultrasound, and the sleep lab.

"Any physician in our area can take advantage of this service when sending their patient to our facility," Salyer explains.

In recent months, the team is facing some new challenges with authorizations.

"We have seen a major increase in denials for medical necessity, pre-service," Salyer reports. *(See the department's chart on the back page of this issue showing claims denial trends.)*

Payers are asking for more "peer-to-peer" consults to obtain the authorization. In these cases, patient access turns over the authorization process to the physician's office.

"This jeopardizes the scheduled visit," Salyer says. "Many times, the insurance company does not make this request until just 24 hours prior to the visit."

Payers take between three and 10 days to obtain the authorization for diagnostic services.

"We have utilized technology that uses a combination of messaging and 'screen scraping' to pull the authorization, once available, back into our health information system," Salyer reports.

If the physician's office already has initiated or obtained the authorization, the system feeds the information into the hospital's EPIC system.

"If our team initiates the auth, the system will continue to 'ping' the payer until the auth message is returned," Salyer explains. "It's not perfect, but it helps."

This speeds the process considerably, since registrars don't have to constantly call payers or physicians' offices to learn the status of the authorization.

"This process is much like the automated notification of admission used by many facilities," Salyer notes.

'No Auth' Denials Rising

The department recently started tracking the number of "no authorization" denials and delays in authorizations.

"We have seen a marked increase in full denials for service, prior to service," Salyer says. "We have tied delays in authorizations to payer delay, and not process delay."

Patient access collaborates with the contract management team to combat this problem.

"We are working to find ways to negotiate an expedited authorization process," Salyer says, noting the department uses this "10-5-1" day rule for scheduling:

- **If clinicals are not sent with the request for a procedure that requires an authorization, the procedure cannot be scheduled any closer than 10 days**.

The authorization team then works with the physician's office to obtain the necessary records.

"If obtained timely, the visit can be moved up in the schedule," Salyer adds.

- **If clinicals are sent at the time of scheduling, then the procedure can be scheduled within five days**.
- **Urgent or emergent procedures can be scheduled the same day or within one day**.

"But in those cases, we will need

EXECUTIVE SUMMARY

Patient access sees significantly more claims denials for medical necessity and more requests for peer-to-peer consults at Chesapeake Regional Healthcare. The department made these changes:

- Registrars avoid time-consuming calls by pulling authorizations from the payer's website into the registration system.
- The physician's office assists in obtaining authorizations for urgent or emergent procedures.
- If an authorization is not in place, registrars tell patients they may be held responsible for the payment.

to utilize the physician's office to assist us in obtaining the authorization," Salyer says.

If a physician already has an authorization on file, scheduling is expedited for the next available time slot, if convenient with the patient.

"If a patient arrives without an authorization, we require a letter of understanding be signed," Salyer says, noting that this informs the patient that an authorization is not on file, and they may be held responsible for the payment.

If this form is not obtained, the patient must be held harmless for payment per the hospital's contractual agreements.

"The pre-registration team communicates this information in advance to patients as soon as it is known that an authorization is not on file," Salyer says. ■

SOURCE

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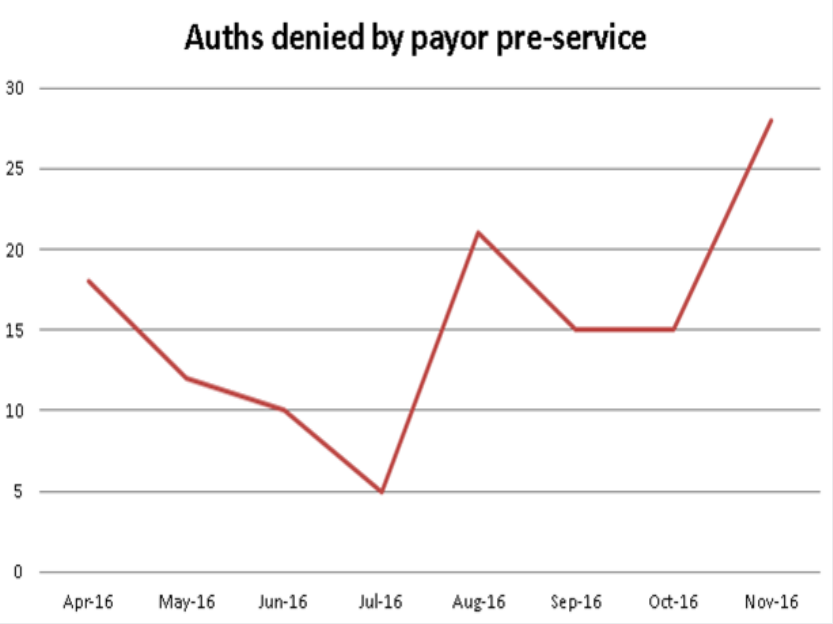
Department Tracks Surge in Denied Auths

The patient access department at Chesapeake (VA) Regional Healthcare tracked a recent increase in the number of denied authorizations, pre-service, per month for six months in 2016.



COMING IN FUTURE MONTHS

- Effective responses if patient access is asked to do more
- Accurately measure productivity in registration
- Put a stop to costly "medical necessity" claims denials
- Creative ways to offer flexible hours and at-home roles

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