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Upfront Collections Increased by $3 Million With Preservice Financial Clearance Process

Simple, consistent processes boost revenue

Upfront collections at Springfield, MO-based CoxHealth totaled about $800,000 in 2015, but soared to $1.4 million the following year. "We are on track to surpass that number for 2017," reports patient access supervisor **Rebecka Sandy**, CHAA, CHAM.

The department's secret weapon is a new preservice financial clearance process. "We have strived to automate our workflow with real-time data," says Sandy. The new process includes the following:

- medical necessity checks;
- benefit verification;
- estimate preparation;
- patient education on out-of-pocket responsibility and payment options.

Several years ago, the department added a financial clearance process for uninsured patients. "This consisted of a one-on-one meeting with our counselors to educate the patients on their options," says Sandy.

"WITH CHANGES TO INSURANCE PLANS, THE DAYS OF OWING A SIMPLE COPAY OR SMALL COINSURANCE AMOUNTS ARE LONG GONE."
—ALYSSA MCDONNOLD, TEXAS HEALTH RESOURCES

This is done for every uninsured patient scheduled for a non-emergent outpatient test or procedure. If patients fall into the hospital's charity policy guidelines, financial assistance is offered. "Payment options can be provided, and may consist of a no-interest bank loan," says Sandy.

Patient access recently automated these parts of the process:

- **Referrals to financial counselors are done electronically.**

Previously, if patients needed help with their out-of-pocket costs, patient access emailed financial counselors to set up a referral. "This was not optimal, because referrals could easily be

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EXECUTIVE SUMMARY

With a preservice financial clearance process, Cox Health increased annual point-of-service collections to $1.4 million from $800,000; Texas Health Resources' collections rose from $8 million to $11 million.

- Patients meet one-on-one with a financial counselor.
- Doctors' offices set up meetings with financial counselors electronically.
- All hospitals within a system use the same policies for financial clearance.
- Tools including payers' contracted amounts offer better estimates.

overlooked," explains Sandy.

Now an automated process is used. "Any doctor's office or patient can easily make an appointment with a financial counselor, using a link to the scheduling system," says Sandy.

Self-scheduling allows patients to pick a time that's most convenient for them. It places the appointment automatically on the financial counselor's calendar.

With this method, "nothing is overlooked, and productivity for the counselors is easily tracked," says Sandy.

• Estimates are done using an automated tool.

Preservice employees used to have to call insurance companies or visit their websites every time they wanted to obtain benefit information. This was very time-consuming and, often, inaccurate. "Creating an accurate estimate was very challenging because of limited access to contracted rates and pricing," says Sandy.

The department recently implemented an automated tool (Availity, based in Jacksonville, FL) to run insurance eligibility and create estimates. "All of our contracts and pricing are built in. It is quick and convenient for the registrar," says Sandy.

Some self-pay patients are surprised to learn they are eligible for coverage, reducing charity dollars. "Securing insurance coverage for some individuals increases revenue for the hospital," says Sandy.

Consistent Practices

The financial clearance process at all of Arlington-based Texas Health Resources' 24 hospitals was revamped recently. High-deductible plans and soaring out-of-pocket costs were the main drivers of this big change.

"With changes to insurance plans, the days of owing a simple copay or small coinsurance amounts are long gone," says pre-access director **Alyssa McDonnold**, CHAM.

Patient access leaders looked closely at the following three metrics:

1. Patient satisfaction scores.

2. The number of calls patients received about their accounts when an upfront deposit was due.

Before, there were two separate steps: preregistration and financial clearance. This meant patients were getting too many phone calls.

Patients usually were called one to three times before preregistration was completed — and then got several more calls for the financial clearance process.

"The new process has cut it to under two phone calls," says McDonnold. Some patients get no call at all, since incoming calls are now transferred directly to the scheduling departments.

"In these cases, we can have a

one-call resolution," says McDonnold. "The patient doesn't get outbound calls, and the center doesn't take up resources making them." Other patients get a single call, with preregistration and the full financial clearance conversation done at the same time.

3. The time between appointments being scheduled to the account being financially cleared for service.

"So many phone calls to the patient delayed accounts from being financially cleared," explains McDonnold.

Based on these three important metrics, says McDonnold, "we knew that we had a need for improvement."

The previous process was very inefficient. First, the Pre-Access Service Center determined that the patient could not meet minimum deposit requirements. Next, the account was forwarded to financial clearance for review and follow-up.

"This was creating inconsistency with financial clearance practices across the system," says McDonnold.

A centralized approach to financial clearance was implemented in 2016. All hospitals now use the same process.

"We took the financial policy and added detailed specifics on what would be done at each stage depending upon the patient's financial situation," says McDonnold. This ensures all cases are financially cleared before the date of service. As a result, upfront collections increased from $8.3 million in 2015 to $11.6 million the following year.

"The financial screening process includes a review of the case by the ordering physician for medical urgency, continuum of care review, family poverty level review, Medicaid referral, and outstanding balances that the patient owes," says McDonnold.

Patients appreciate getting fewer phone calls. Before the new process was implemented, satisfaction scores were stalled at 67%, but have since risen to 88%.

"There are fewer outbound phone calls, and scripted, detailed explanations are given to patients so they are aware of all their options," says McDonnold. (*See sample scripting used by the department in this issue.*) ■

Say This to Financially Clear Accounts

Registrars at Arlington-based Texas Health Resources' 24 hospitals use the following scripting when having financial discussions with patients.

• For self-pay patients: "Based on the information you have provided today, the estimated cost for this procedure is ($). We give all self-pay patients a discount, which brings your estimate to ($). Please keep in mind that this is only an estimated calculation, and could change depending on the services your physician performs."

• For insured patients: "According to an online check of your insurance benefits, the deposit amount due for this service is ($). Please keep in mind that this is only a deposit calculation based on your benefits from the automated system. Once the insurance company processes the claim, you may be billed for any additional amounts that you owe. They may not pay for all or part of your services, based on your benefits at that time. I must also advise you that this deposit calculation includes the hospital bill only. You will be billed separately for other physician services."

SOURCES

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Have Plan B for Unexpected Call-outs: Reduce OT

Make inadequate staffing a thing of the past

If registration areas are understaffed during peak volumes, two bad things happen very quickly: Wait times surge, and patients are unhappy.

"Patient safety and traffic flow are immediately impacted when there is inadequate staffing in a registration area," warns **Jason Guardado**, manager of patient access at Nyack (NY) Hospital.

Patient care, registration quality, and customer service all suffer. When

EXECUTIVE SUMMARY

Registration staff at Nyack Hospital are trained to cover any area on a moment's notice, resulting in a 50-hour reduction in annual overtime hours. The following steps can help prevent overstaffing.

- Give competency assessments to ensure staff understand processes.
- Schedule a "floater" during peak volumes.
- Rotate floaters to keep them updated on changes.

short-staffed, says Guardado, "staff is solely focused on getting through the registration process, rather than providing service excellence to each patient."

Tough Decisions

The emergency department (ED) is the biggest staffing challenge for many patient access departments. One reason is the need to provide coverage 24 hours a day, seven days a week. Unexpected call-outs can wreak havoc on ED registration processes.

"This puts a strain on management, who have to make decisions on mandating staff to stay past their scheduled shifts," says Guardado. For unionized institutions, this is particularly difficult. "Management and non-union staff members are unable to cover the area until another staff person can provide the coverage," Guardado explains. Here are some strategies to prevent understaffing in registration areas:

• Ensure that all registration staff are able to cover any area on a moment's notice.

In January 2017, Nyack Hospital began cross-training all registrars — even those who work weekends or nights. If necessary, patient access managers step in to do the training themselves. "Competency assessments ensure staff comprehend processes," says Guardado. Registrars answer five to 10 questions on key points of the particular registration process. "The questions also identify some form of compliance or quality assurance component that must be followed," says Guardado.

Once the test is scored, employees meet briefly with management. "We discuss the score and provide clarification on any questions that were answered incorrectly," says Guardado.

If staff have difficulty understanding a process, the trainer or an experienced employee does some one-on-one review. "If staff continue to struggle, management schedules a 'performance counseling,'" says Guardado.

Some registrars find it difficult to scan the correct documents into the patient record when working in the fast-paced ED setting. "Although quality measures and best practice methodology has been implemented, staff still must be vigilant," says Guardado. Registrars contact management immediately about any scanned document errors, so they can remove the document from the wrong patient record and place it into the correct one. "This has to be done no later than midnight of the day of the infraction to ensure it does not get identified by Health Information Systems' medical records division," Guardado explains.

Employee turnover has decreased slightly since cross-training was implemented. However, a change in morale has been much more noticeable. "There has been an obvious reduction in employee burnout and employee dissatisfaction," says Guardado.

Another plus: Overtime costs have plummeted. "From July 2016 to July 2017, we saw a reduction of over 50 hours in OT," reports Guardado.

• Schedule a "floater" during peak volumes.

"This alleviates some of the stresses that come with unanticipated surges in patient volume or shortage of staffing resources," says Guardado.

The department's floaters are well-versed in all registration areas. These highly skilled employees cover the ED, the admitting department, outpatient centers, inpatient admissions, bed control, and radiology. (*See related stories on cross training and "floaters" in this issue.*)

"They are called upon at any given moment to assist with registration duties when needed," says Guardado.

The floater is the go-to solution if a registration area is in dire straits. During off-hours, though, a Plan B is needed. "Having someone available 24 hours a day is impossible, unless you are able to staff more than one on a consistent basis around the clock," says Guardado. If no floater is available, the solutions become tougher: Registrars may need to work mandatory overtime, or patient access managers step in to cover.

Floaters frequently rotate to all areas. This keeps them up-to-date on changes and new processes.

"This staff person will receive the best training and information to succeed in their role — but usually will have the most inconsistent work schedule and shifts handed to them," says Guardado.

• Create a registration pool.

Registration areas have consistent, steady staffing despite absences and medical leaves at Abington-Jefferson

Health/Aria-Jefferson Health in Philads. "We then hire permanent slots from this pool and backfill the pool with new hires," says **Kim Roberts**, MBA, RHIA, CRCS-I, vice president of the revenue cycle.

The department is looking to create a similar pool for the central scheduling department. "A different skill set is required," notes Roberts. "But again, we would look at it as an ongoing resource for coverage in the event of call-outs and vacancies." ■

SOURCES

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- Kim Roberts, MBA, RHIA, CRCS-I, Vice-President, Revenue Cycle, Abington-Jefferson Health/Aria-Jefferson Health, Philadelphia. Email: Kim.Roberts@jefferson.edu.

Cross-training's True Return on Investment: A Better Patient Experience

Quicker throughput = satisfied patients

Cross-training is critical to the success of many patient access departments.

"My team floats around, often filling in for areas that are down in staffing," reports **Kim Rice**, MHA, director of patient access at Shasta Regional Medical Center in Redding, CA.

If a registrar calls in sick, for instance, an outpatient scheduler can step in to register patients. "Once the staff get caught up, the scheduler will go back to scheduling," says Rice.

The same approach is used during sudden volume surges. "Even when the department is fully staffed, I will pull someone from another position and have them register," says Rice. "This keeps the patient flow moving."

Very Different Flow

Scheduling is done the same way, in the same system, regardless of the registration area. Jobs differ in other important ways, however. Radiology and perioperative are both registration roles, for instance, with very little scheduling involved. "But the flow of what happens is very different," says **Marion Knott**, manager of clinic access at Tampa, FL-based Moffitt Cancer Center.

Both areas need to get all the necessary forms completed, but these differ depending on why the patient is there. Although radiology enters clinical information into a separate system for patients who leave after the procedure is completed, the perioperative floor deals with patients who are being admitted.

"Very different information is needed than with an outpatient appointment," says Knott. For example, Medicare patients complete a form outlining their rights as an inpatient.

Finding a pool of well-trained registrars who understand these nuances is not easy. It begins with two weeks of classroom training given to all new hires. This covers all aspects of registration and scheduling — but only for the area for which registrar the was hired.

"When they come out of training, they spend a couple of days observing at the clinic they're going to work in," says Knott. Working with a peer allows employees to fine-tune their registration and scheduling skills.

"This gets them fully acclimated to the area they're hired for," says Knott. "Then, if they're interested, we trade them off to other supervisors to learn other areas."

This is an integral part of the department's career ladder. "Everybody comes in at a Level 1," explains Knott. To get to Level 2, employees must be cross-trained for all of their supervisor's areas. Level 3 requires even more cross-training in another supervisor's area. (*See the department's eligibility requirements in this issue.*)

"Each promotion gives them a merit increase," says Knott. "This encourages them to be proactive with their learning."

Knott, who started out years ago

EXECUTIVE SUMMARY

Cross-training registrars improves patient satisfaction with shorter waits and improves employee satisfaction with opportunities to advance.

- Include cross-training requirements in career ladders.
- Ask prospective candidates if they are interested in cross-training.
- Choose employees who are enthusiastic about cross-training.

as a patient access representative, is an advocate of cross-training based on personal experience. "I was the one always chosen to 'go float.' The experience from doing that years ago helps me today," she says. If a clinic reaches out for help because a supervisor is unexpectedly out or overwhelmed, Knott can be counted on to cover for him or her.

The group of cross-trained registrars has a big advantage when it comes to career advancement. Many have taken on different jobs in patient access.

These opportunities are highlighted at the department's annual "town hall" meeting, which educates employees on all of the various paths to advancement within the revenue cycle.

"The people who want to grow, do grow," says Knott. "Many have moved on to roles in training, escalation, financial clearance, or the call center."

Help, From a Distance

Cross-training has helped patient access to fill unexpected staffing gaps many times. Recently, all of a clinic's providers were away at the same conference, so no orders were coming in and staff had little to do. Another clinic was overwhelmed and asked for help. Sometimes, registrars can stay at their physical locations while helping out. "They can help each other at a distance, since all orders come across electronically," Knott explains.

Cross-training also helped during Hurricane Irma. Even though the storm was not expected to make landfall in the Tampa Bay area until Sunday night, many staff members evacuated as early as Thursday night. "We were still open until Saturday," says Knott. "Because we had so many team members cross-trained, we were able to provide coverage in all clinics."

Career Ladder for Financial Clearance Specialist

New patient access team members all start out as "Level 1s" at Moffitt Cancer Center in Tampa, FL. "After six months on the job, they can apply for advancement," says **Marion Knott**, manager of clinic access. Below are the eligibility requirements for a patient service or financial clearance specialist:

1. The employee must meet or exceed standards on the most recent performance evaluation.
2. The employee must consistently follow all policies, clinic and revenue cycle guidelines, and the Code of Ethics and Professional Conduct, as evidenced by the lack of any disciplinary action or written counseling in the preceding six months (does not include documented coaching or documented verbal counseling).

The following steps are used if employees wish to be considered for advancement:

1. Team members must submit a form documenting their attainment of the requirements and a form demonstrating maintenance of the requirements. The forms are due during the first application window after the team member has had 24 months at the current level. If these team members do not submit documentation during the application window following 24 months at an advanced level, they will be re-leveled as a "1."
2. Two application windows are offered each year: one in the fall, and one in the spring. Applications are available from supervisors or managers. Applications are reviewed by the director, manager, and supervisor to ensure consistency. A decision is communicated to the team member within one month of the application.
3. Team members can request a voluntary movement down the ladder at any time because of an inability to meet expectations or personal preference. ■

The following are strategies for successful cross-training:

• Carefully choose which employees to cross-train.

At Hackensack Meridian Health — Palisades Medical Center in North Bergen, NJ, patient access leaders evaluate employees' performance and productivity. They identify those with the "right stuff" to be cross-trained.

Not all employees are suited for this. "It all depends on their demeanor, strengths, and overall performance," says patient access director **Maria Lopes-Tyburczy**, CHFP.

Cross-training employees takes time and money, but departments report a trickle-down effect: Patients are happier. "Better patient throughput in registration areas, in turn, improves the overall patient experience," explains Lopes-Tyburczy.

Good decisions on which registrars to cross-train means a good return on the investment. "If they retain what they've learned and are available when needed, it can be cost-effective in the long run," says Lopes-Tyburczy.

• Ask potential new hires if they're interested in cross-training.

This sends a strong message that there's opportunity for advancement, says Rice. "Usually, this sparks their interest in the position even more." ■

SOURCES

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Trust Patient Access Employees With These Important Projects

Involving registrars is "win-win"

Are you brainstorming for ideas to improve your patient access department? Look no further than your best registrars.

"We encourage our employees to participate in projects and committees focused on process improvement and patient experience," says **Jackie Jordan**, MBA, CHAM, patient access and scheduling manager at Kadlec Regional Medical Center in Richland, WA.

This allows the employee and the department to reach important goals.

"It provides the team with front-line employee knowledge, and helps the employee build their skills through project work," says Jordan. "Together, it's a win-win."

Andrew Moreno, CHAA, a patient access lead at Kadlec Regional, has worked on many departmental projects. "It is very important to let employees know that their opinions and efforts matter to the department," he says. "Employees may have a better solution!"

The first project Moreno worked on was a simple yet important one — creating a department inventory list. "Using the list, I can determine what supplies are needed, and when to order more supplies," he says.

Subsequent projects centered around cost-reduction. "I figured out that it would be cheaper to make copies of necessary documents in our department rather than ordering them through the print shop," he says. However, Moreno later learned that it wasn't quite that simple. The quality of the copied documents wasn't good enough. Also, the department's copy machines were overloaded.

"Another reason why this method wasn't implemented is the amount of changes that can happen to the documents. Ordering through the print shop ensures the most up-to-date documents," explains Moreno.

However, another of Moreno's waste-reducing ideas was a keeper. It involved documents prepared by patient access. These used to be done for all of the following day's appointments — some of which ended up being cancelled.

The department now prepares documents only for early-morning appointments. At that time of day, staffing is minimal, so pre-prepared documents are a great help. "This helps with check-in times," says Moreno.

Improved Workflow

Moreno recently participated on a Patient Access Task Force, which included team members from the ED, the authorization unit, central scheduling, the outpatient imaging center, and the main hospital's registration area.

"Together, we found ways to improve workflow and reach some of our goals," says Moreno. Annual point-of-service collection goals were one area of focus, but the target amounts seemed unrealistic to some employees. "Instead of seeing a figure in the millions, I was able to break it down on a per-person basis to a figure

EXECUTIVE SUMMARY

Patient access employees appreciate being asked to participate in projects, and the department benefits from their feedback. Below are examples of employee-led projects at Kadlec Regional Medical Center.

- Create inventory lists.
- Find ways to decrease the number of cancelled appointments.
- Determine collection goals for individual registrars.
- Identify what takes registrars away from their standard workflow.

in the hundreds per day," Moreno says.

The task force also tackled the costly problem of failing to obtain required authorizations from payers. An authorization requirement was added to the scheduling questionnaire to make sure the authorization is obtained prior to scheduling.

Next, the group identified common occurrences that took registrars away from their normal workflow. Doctors' offices sending patients over without complete orders fell into this category.

"By communicating with the appropriate department or caregivers on ways to improve, we were able to see a decrease in these trends," reports Moreno.

Moreno credits his own high morale to the employee-led projects: "Having expectations that go above the routine job description brings a high level of self-worth."

Regulary meetings with Jordan are an important part of the process, says Moreno: "I can learn the skills needed from her experiences while building mine in the process." ■

SOURCES

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'Floater' Reduces OT and Burnout

Position offers career advancement

About 150 hours a year in overtime is no longer needed in the patient access department at Ochsner Health Systems, Westbank Region in Gretna, LA. This is because of a new "floater" position created several years ago.

The floater is able to cover all patient access roles, even the emergency department (ED). "We identify strong employees within the ED, who are already working weekends and rotating shifts," says **Sherry Whitefield**, CHAM, director of patient access services.

ED registrars usually jump at the chance to become a floater. "The main reason is for the opportunity of being scheduled Monday to Friday during normal business hours," says Whitefield.

Since the floater position was implemented three years ago, the percentage of patient access employees who say they are "actively engaged" has increased from about a third to about half of the department. The likely explanation: They're no longer working short-staffed. This means personal days and vacation time are more likely to be approved. "Having the floater allows us to be able to approve personal time-off requests," explains Whitefield.

All Areas Covered

The same training process is used for floaters as for other registration roles: The employee shadows the process and is trained by the supervisor. "After a few days, the supervisor then shadows the employee and reviews our competency checklist," says Whitefield. The difference is that floaters do this for all areas — but only move to a new area after they're fully comfortable with the processes and procedures of the first area. "At that time, the employee then moves on to the next area to begin the training, until the employee has completed all areas," says Whitefield. After training is completed, the floater covers whichever area has the greatest need.

Patient access leaders work together to create the floater's schedule. "The floater and her leaders know what areas she will be working a month in advance," notes Whitefield. "Whatever department she is scheduled to work in, her time is coded to that cost center."

The floater works 40 hours a week without incurring any overtime. "This has been a great success for patient access," says Whitefield.

Floaters have left the position only for advancement opportunities, such as clinic scheduling, inpatient verification, and outpatient registration. "Employees find what they feel is their 'fit,' with opportunity for growth," says Whitefield.

That includes leadership roles. Two of the floaters are now patient access supervisors. Another is a team lead in the department. "Being trained in several areas offers a wider knowledge range — and career advancement," says Whitefield. ■

SOURCE

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Too Many 'John Does?' Tighten Processes for Unidentified Patients

Names might be too similar

Recently, six patients, including several children, presented to the ED at Maine Medical Center in Portland after an accident. None had any identification.

"We had issues around the names and dates of birth being too similar," says patient access manager **Patty A. Johnson**, CHAM. This called attention to concerns about the process used for unidentified patients. "It works well, except if we were to have a mass event. The names are too close for comfort," says Johnson. When multiple anonymous patients presented simultaneously, it caused confusion for clinical staff.

To address this issue, the department created new procedures for patients whose identity is unknown at the time of arrival. These steps are taken:

1. Registrars select a checkbox for "anonymous." This creates a unique name and medical record number for the patient.

2. Anonymous patients use a combination of XXGreek/NATO characters for first and last name, and four random letters are used as a middle name, such as "XXDigamma, Theta CWSY."

3. The anonymous patient date of birth is 01/01/1901, except if the patient is a minor. If the anonymous patient is a minor, the date of birth can be manually changed to reflect the patient's estimated age. "Previously, the date of birth used for anonymous patients did not allow clinical staff to access pediatric clinical dosing calculations," explains Johnson.

4. The anonymous patient's Social Security number is entered as "111-11-1111."

5. Once patient access has identified the patient, the name, date of birth, and Social Security number are updated. "If the patient does not have an existing medical record number, the patient keeps the medical record number originally assigned to the anonymous name," says Johnson.

Safety Concerns

Unidentified patients present risks that go beyond revenue loss. There is always a chance the patient will be misidentified by the clinical team.

"Patient safety is a concern when patients are not able to be properly identified," says **Dahlialee Gonzalez**, patient access manager at Hackensack Meridian Health — Palisades Medical Center in North Bergen, NJ.

Video Shows Patient Identification Best Practices

An educational video on patient identification best practices was a great help to the patient access department at Hackensack Meridian Health — Palisades Medical Center, North Bergen, NJ. "The video spread awareness throughout the organization of the importance and critical aspect of the role of patient access in Patient Identification," says patient access manager Dahlialee Gonzalez.

These three scenarios were used:

1. A "quick reg" is done in the ED.

The video showed the registrar asking for two identifiers — the patient's name and date of birth — and the patient presenting legal ID.

2. A patient presents to radiology for a study.

The video shows the registrar asking for two identifiers: the patient's name and date of birth. Once the patient is registered, the radiology technologist compares the name and medical record number from the patient's ID band with the order, to ensure it's the same person.

3. An inpatient is not wearing an ID band and the patient is unable to speak.

The video shows the nurse checking for the patient's ID band and notices it missing. The nurse immediately calls patient access, and a patient access representative goes to place the ID band on the patient. Before the band is place on the patient, the primary nurse identifies the patient to ensure the name and medical record number are the same," says Gonzalez.

Patient access helped the "actors" to understand their processes completely before the video was filmed. "This ensured they followed the exact process that we have in place," says Gonzalez. ■

EXECUTIVE SUMMARY

Unidentified patients pose safety concerns because of the possibility of duplicate medical record creation and patient misidentification. The following approaches may help minimize safety concerns.

- Use different dates of birth for pediatric and adult patients.
- Take and store a photo of all patients presenting for services.
- Create a video on patient identification best practices

The department recently implemented finger scanning technology. This makes identification effortless if patients were seen at the facility previously. "It helps minimize the creation of duplicate medical record numbers," says Gonzalez. "We also take and store a photo of all patients presenting for services."

If the patient has an existing medical record number, registrars check the photo on file to be sure that is indeed the same person. However, this isn't always possible during a mass casualty event or disaster. "At times, we are not able to perform the finger reader function due to the patient's condition," says Gonzalez.

If multiple unidentified patients present at the same time, a number sequence is used to identify them, such as John Doe 1 and John Doe 2. The department has not had a mass casualty event or disaster that involved unidentified pediatric patients. The current process uses a uniform date of birth for all unidentified patients.

"The process will need to change if children are involved," acknowledges Gonzalez. "For children, we will need a different date of birth that would identify the patient as a child." (*See related story on a patient identification video created by the department, in this issue.*) ■

SOURCES

- **Dahlialee Gonzalez**, Patient Access Manager, Hackensack Meridian Health Palisades Medical Center, North Bergen, NJ. Phone: (201) 295-4801. Email: Dahlialee.Gonzalez@hackensackmeridian.org
- **Patty A. Johnson**, CHAM, Patient Access Manager, Maine Medical Center, Portland. Phone: (207) 662-2102. Email: johnsp@mmc.org.

Avoid Lost Revenue Caused by Insurance Eligibility Mistakes

Automated insurance eligibility tools make a tiresome task quick and easy for patient access employees. However, responses can be surprisingly difficult to interpret.

At Ohio State University Wexner Medical Center in Columbus, patient access uses a manual process for a small number of payers without the ability to verify transactions electronically. "You either collect a copy of the insurance card or call the payer to confirm eligibility," says **Kathy Herrick**, manager of registration quality assurance.

For most payers, an automated eligibility tool is used. "It's a good tool, but the problem is that you don't always get consistent responses. That is challenging," says Herrick.

The electronic response is not always clear cut. It can be difficult for employees to interpret. "You'd think it would be as clear as a 'yes/no' answer. But it's not always that way," says Herrick.

If eligibility responses are interpreted incorrectly, claims denials are inevitable. To address this, the department made these changes:

• Revenue cycle trainers created an "Advanced Insurance and Eligibility" course.

The four-hour in-service for new hires covers the basics of eligibility responses, plan selection, effective

EXECUTIVE SUMMARY

Patient access staff can interpret responses from insurance eligibility software incorrectly, causing lost revenue. The following tips can help prevent mistakes.

- Create an in-service for new hires on interpreting the responses.
- Post information on eligibility responses on the hospital's Intranet.
- Ask staff to alert managers if a payer's response looks unfamiliar.
- Involve the managed care department for problems with payers' responses.

dates, and guarantor accounts. Staff are also given helpful information on specific payers.

"All staff working with insurance or registration are required to complete this class. It's dedicated to looking at eligibility responses and interpreting them," says **Deb Wharton**, manager of revenue cycle training.

• The department posted insurance coding information on the intranet.

After clicking on a specific payer, registrars can view a sample insurance card and sample eligibility response. "By looking at examples, staff can better understand how to code and how to select the appropriate payer and plan," says Wharton.

Unexpected Changes

Eligibility responses don't always look as staff expect them to. "An example would be an alert telling you to change an insurance plan code, but the information in the response does not identify with that plan," says Wharton.

Sometimes confusion occurs because of something the payer changed without notifying the hospital. For instance, an employee group number may have changed. "Unannounced changes are challenging," says Wharton. "We alert staff with a blast email."

If staff notice something that does not seem quite right, they are encouraged to alert managers immediately. "Front-end staff will certainly see things quicker than we will," says Herrick. "We have to rely on them." For example, registrars may complain, "Every time I put this through, we are getting this response from the payer — but we never used to. What's going on?"

It might be necessary for someone to speak with a payer directly. If that's the case, the hospital's managed care department gets involved. "We also use a third-party eligibility vendor who has extensive payer contacts. Depending on the issue, we may work with both," says Herrick.

Sometimes the problem is that the payer's website has different information than the electronic eligibility tool is giving. "We do find that occasionally, and we then have to work with the payer to rectify it," says Herrick. Last year, a payer was denying eligibility for members of an employer group because the employer gave the payer incorrect information for the payer's set-up. "There were lots of denials, which resulted in a call with the payer," says Herrick. ■

SOURCES

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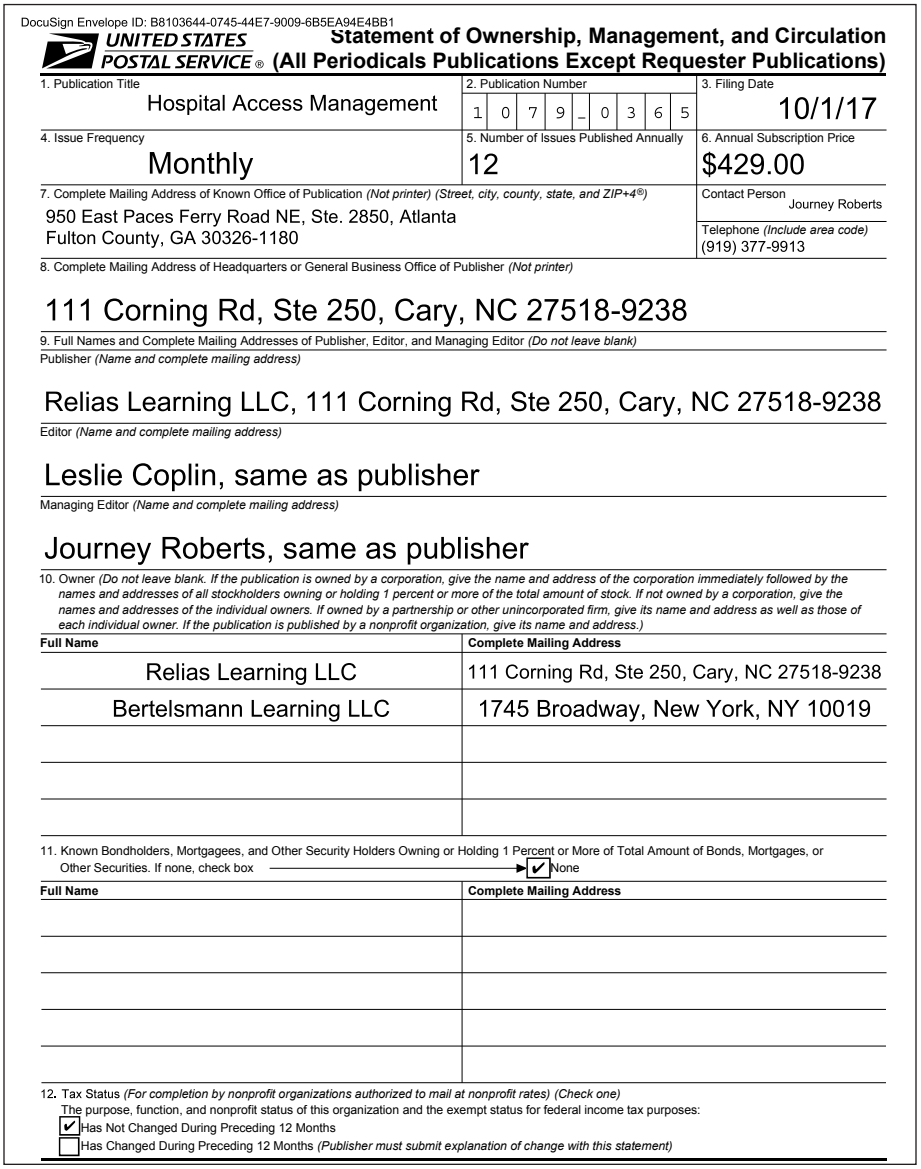

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