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RELIAS MEDIA

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Abdominal Pain Was Not Appendicitis? Entire ED Visit Could Be Denied

After an extensive evaluation, it turns out that an ED patient with severe abdominal pain does not have appendicitis, only constipation. This is good news medically; financially, it is a different story. The patient may end up fully responsible for the entire cost of the ED visit, deemed "unnecessary" by the insurer. For the revenue cycle, this means lots of complaints, lost revenue, and bad debt.

About 15% of ED visits could be denied if a leading insurer's policy is implemented nationwide, according to the authors of a recent study.[1] Under Anthem Blue Cross/Blue Shield's "ED review" program, claims can be denied based on the patient's eventual diagnosis. Several other insurers have since adopted similar policies.

Anthem's program was put into place to reduce inappropriate use of EDs for nonemergencies, according to spokesperson **Joyzelle Davis**. "If a consumer receives care for a nonemergency condition at the emergency department when a more appropriate setting is available, Anthem will request more information from the hospital *and* a statement from the consumer as to why they went to the ED," says Davis, adding that an Anthem medical director will review the additional information using the prudent layperson standard.

"We know from previous studies that judging the appropriateness of ED visits after the fact is problematic," says **Andrew Chou**, MD, MPH, the study's lead author and an attending physician in the department of emergency medicine at Brigham and Women's Hospital in Boston. One study revealed that an insurer's list of nonemergent diagnoses would classify 16% of commercially insured adult ED visits for possible coverage denial.[2] However, these visits shared the same presenting symptoms as 88% of ED visits, of which 65% received emergency-level services.

There is ample evidence that retrospective diagnosis-based policies cannot accurately identify unnecessary ED visits. Despite this, some state Medicaid programs collect a $5 or $50 copay for ED visits deemed "inappropriate." But several of the new policies, including Anthem's, says Chou, "takes the financial stake to a much higher level by denying *any* payment for the ED visit."

Since Anthem is one of the nation's leading insurers, researchers anticipated that this practice could spread to other

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companies. That has since proved to be the case, with two other insurers implementing similar policies. Harvard Pilgrim applies a 50% coinsurance for New Hampshire policyholders whose final diagnosis is determined to be nonemergent. Blue Cross and Blue Shield of Texas will not pay anything for an out-of-network ED visit if the insurer later determines the patient should have gone elsewhere for treatment.

To find out how many ED visits could be denied if similar policies continue to be adopted nationally, researchers studied visits of more than 28,000 commercially insured adults. They found that the insurer's list of nonemergent diagnoses would classify coverage denial for 4.6 million ED visits annually.

"Our findings were consistent with prior studies," Chou says. People with nonemergent diagnoses can present with diverse symptoms. Some of these, such as chest or abdominal pain, would trigger most outpatient clinicians to refer their patients to the ED for evaluation.

A person with a sudden, severe headache could reasonably fear a ruptured aneurysm, but be diagnosed with a migraine. Since it turned out there was no emergency, the entire cost of the ED visit and diagnostic tests could be denied. Although Anthem has since released a list of exceptions the company says it always will cover (including chest pain, difficulty breathing, seizure, convulsion, fainting, and drug ingestion or overdose), patient safety remains a concern. The well-publicized policies could affect people who avoid going to the ED, fearing a massive bill.

"A patient who needs ED care may not seek it in a timely fashion because they worry they may not be covered," Chou adds. It is not hard to imagine how patients will react to finding out their insurance is not paying a dime for their ED visit. If patients are unable to pay, it means bad debt for the hospital; exactly how much is unclear. "There's not a lot of publicly available data to demonstrate how much this impacts hospital revenues," Chou notes.

Even health insurance companies stand to take a financial hit from their own new ED coverage policies. "The insurer needs to invest a significant amount of resources to review these cases," Chou says. Interestingly, most appealed cases were ultimately approved and paid, according to a July 2018 report from the office of former Sen. Claire McCaskill, D-MO.

Anthem denied about 12,200 ED claims in Missouri, Kentucky, and Georgia from the last half of 2017, but overturned 62%, 60%, and 70% of the denials that were appealed, according to the McCaskill report.

"There's really not a clear winner from this policy," Chou adds. The insurance policies are based on the presumption that it is possible for a person to know whether he or she is experiencing an emergency — in effect, to diagnose themselves. "Many times, that determination is not so clear-cut," Chou says.

Even triage nurses thought that one-quarter of patients who ended up with a nonemergent diagnosis were either urgent or emergent cases and needed to be seen in a timely fashion, according to the study authors. So what would happen to these patients if they did not seek ED care?

"When we use a policy to try to turn patients away from the ED, sometimes they don't have another place to go," Chou says.

Such controversial ED policies are facing some pushback. In July 2018,

the American College of Emergency Physicians and the Medical Association of Georgia filed a federal lawsuit asserting that Anthem's Blue Cross/Blue Shield Healthcare Plan of Georgia is violating the prudent layperson standard (a federal law requiring insurance companies to cover the costs of emergency care based on a patient's symptoms, not their final diagnosis). In a court filing in September 2018, Anthem asked that the lawsuit be dismissed, stating that the goal of the policy is to reduce inappropriate use of EDs. *(Editor's Note: A copy of the entire lawsuit can be found online at: https://bit.ly/2LpeKoN and a copy of Anthem's motion for dismissal can be found at: https://bit.ly/2RxMYga.)*

As this litigation continues, states are passing legislation that would prevent surprise medical bill. New Jersey's version *(learn more online at: https://bit.ly/2Ts9Fja)*, which became law in September 2018, meant many changes for patient access. "Working with IT, scheduling, and patient access staff is crucial to having a successful implementation," says **Sandra N. Rivera**, RN, BSN, CHAM, patient access director at St. Joseph's Health in Paterson, NJ. Recently, a meeting was held to review the state's surprise medical bill law and the new processes that would be needed. Patient financial services, contract management, physician billing, and patient access all were involved.

"Each area assisted in getting the tools the front end would need," Rivera says. The group gathered information on contracted plans for the facility and physicians. "The challenge for our organization is the decentralized scheduling and check-in at all locations," Rivera notes.

Ultimately, patient access determined that patients must be notified at scheduling if their insurance plan is in network or out of network, where to find additional information on the website, and that they should call the payer for any questions. Registrars also ask patients to sign an acknowledgement that they received the information.

For patients, these efforts might prevent receiving a surprise medical bill. For patient access, says Rivera, it means lots of "planning, setting up policies, and training staff." ■

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To Increase Kiosk Use Rates, Do Not Overlook Personal Connection

Air travelers are so accustomed to using kiosks to check bags and print boarding passes that most do not think twice about it. However, the same is not true of kiosks in healthcare registration areas.

Kiosks are expensive investments that do not always pay off for hospitals. For patient access, kiosks face two big obstacles, according to **David Kelly**, CHFP, MSHA: "The first is that kiosks have to benefit the patient. Often, they don't."

Many kiosks are put in place just for the purpose of "lobby management," which helps the hospital, but does nothing for the patient.

"Put the patient first and make sure they are getting the most benefit. Then, look at the benefit to the organization," advises Kelly, director of revenue cycle and managed care at Mary Rutan Hospital in Bellefontaine, OH. This means investing in a kiosk that can actually do what people expect: check in and registration. This way, the kiosk allows a person to bypass the usual registration process.

"The second obstacle I've seen is the type of patient," Kelly says. Walk-in patients are bad candidates for kiosks. That is because registration takes longer for these patients due to the need to collect all kinds of demographic information. Patients expect the kiosk to speed the process, not force them to stand there typing in insurance, addresses, and Social Security numbers. Better candidates for kiosks? Scheduled, recurrent patients. "They come back time and again with very few changes," Kelly explains.

Kiosks can be offered to walk-ins, but patient access should be realistic. Expect more complaints, lower use rates, and many requests for assistance from staff. "Start other places first," Kelly recommends.

Regardless of who is standing at the kiosk, he or she should not have to go it alone. Staff should be ready to step in when inevitable glitches arise.

"If you have staff to help, if the system has a high up-time ratio, and

it allows patients to skip steps, then satisfaction will come," Kelly offers.

At Mary Rutan Hospital, kiosks are used in urgent care for walk-in patients, with a roughly 12% use rate. "We are looking to repurpose them elsewhere because of the troubles with walk-ins," Kelly reports.

In contrast, more than 200 patients a day use kiosks to check in at the hospital's rehabilitation service line. This equates to a use rate of about 98%, according to Kelly. "We are seeing very positive results there."

Focus on Self-Arrival

At the University of Pittsburgh Medical Center (UPMC), self-arrival technology has been a focus for two years. An executive steering committee was formed to make this a top priority, including hospital administrators, marketing, physician practices (both hospital-owned and within the community), and revenue cycle leaders.

"There was a lot of great buy-in early," reports **Daniel J. McCann**, MBA, director of revenue cycle business operations at UPMC.

Smaller groups were formed to target each area the kiosks were planned for: point of service, the day of arrival, hospital ancillary services, and the ED.

"Our team developed a rollout plan, campus by campus," McCann says. The goal was to supplement front-end staff with kiosks, yet still give patients a great experience. "After the initial kickoff, we brought in all the localized practice managers," McCann says. All employees were brought in for a training session on kiosks.

Concerns about job security were assuaged. "We explained that we are not going to displace staff, we are just shifting their focus," explains McCann. Patients handle simple tasks, such as updating or confirming demographic information. This allows staff to collect copays or enroll patients in a mobile app for scheduling. The department set a kiosk use rate goal of 40%, based on industry standards.

"We now have 63% of arrivals checking in with no-touch registration, which is great," McCann reports. More than 200,000 appointments each month are checked in at kiosks. "We offer the choice, but we are glad patients are choosing the kiosk," McCann says. "It's become an expectation."

Patients are not robotically pointed to a kiosk. Registrars give patients a warm verbal greeting and encourage them to use kiosks while making it clear staff are ready to assist at the first sign of difficulty. "If the patient just wants to be checked in by someone instead, we can do that," McCann says.

Consistent signage and kiosk placement are used for every registration area. This way, the patient's eyes go straight to the kiosk and it is very clear what the kiosk is intended to do.

"The numbers have been very consistent for a long period of time now," McCann says.

The People Aspect

Five optimization specialists visit more than 600 UPMC locations with kiosks to assess how they are used. Mainly, they want to see that the arrival experience for patients is not just average, but excellent. "We're not selling iPhones. We're greeting people who don't want to be there," says McCann.

Biometric recognition is used in tandem with kiosks, with about 500,000 patients in the organization's database. Patients enroll at any UPMC location after their ID is validated. At some hospitals and surgery centers, kiosk users no longer type in their names. Instead, they place an index finger and enter a date of birth, thereby expediting the process.

The team expected low use rates in geriatric locations. "But it's turned out to be one of the highest-utilizing areas," McCann says, attributing this to widespread use of biometrics in other industries, which many people use to access their smartphones. "We can see utilization in real time." Office managers can pull up the daily schedule and see that of 12 patients who checked in, eight used the kiosk. Frequent patients appreciate not having to validate information each visit, since demographic information only appears every 90 days.

On the employee side, they gave up their titles of patient information coordinators. They are now patient services representatives, an indication that the emphasis is on customer service as opposed to just providing information. "Kiosks can do a lot of that," McCann notes. "Who wants to ask people over and over if their phone number is still the same?"

Staffing has decreased, but only through attrition. "We've got to be efficient with our resources," McCann says. "Now that we have 65% of patients coming in through the kiosk, it made sense to adjust staffing."

Employees have turned to more complex tasks, such as explaining why the patient has a copay, scheduling a radiology appointment for a patient leaving the physician's office, or helping people apply for financial assistance. "Our workforce is there to be the ultimate concierge," McCann says. "If we have highly engaged staff, we have highly engaged patients as well." ■

When Rotating Revenue Cycle Staff, Both Employees and Department Win

OSF Healthcare Revenue Cycle Manager **Mark Logan** is cross-training several scheduling and registration employees at two of the organization's facilities: OSF Holy Family Medical Center, a 23-bed critical access hospital in Monmouth, IL, and OSF Saint Luke Medical Center, a 25-bed critical access hospital in Kewanee, IL.

"My hope is to have staff want to learn more and grow within the revenue cycle, allowing us to retain and promote them," Logan says.

At one facility, a financial counselor is cross-training in rehab and outpatient registration. This helped with staffing shortages as well as the patient experience.

"She can also help patients who need assistance with public aid applications or who have billing questions," Logan adds.

At small critical access hospitals like the OSF facilities, patient access employees cover rehabilitation, outpatient, scheduling, and the ED. "Because of our size and volume, patient access services gets spread pretty thin," Logan laments.

Some areas work with only one patient access person on a given shift. Thus, the department is taking a new approach of rotating staff in all four areas. This gives these employees a working knowledge of different department functions.

"Night shift coverage in the ED is always a challenge," Logan notes. "I rotate coverage between several staff to alleviate third shift burnout." If staff cover a third shift, they work for 10 hours instead of eight. "This allows me to give them an extra day off during the week," Logan adds. "It allows greater work-life balance for those who have to work when everyone else is asleep."

The department's biggest challenge: Few people are available to cover for their cross-training colleagues. Taking an employee from one area to train means someone else is pulled from another area to cover for that employee. "This can be a nightmare when making a staff schedule," Logan explains.

Differences at all registration areas are another challenge. The same information is gathered, "but each area has its own unique workflow," Logan notes. For instance, outpatient registration staff conduct a full registration on a patient each time a patient arrives for an appointment. Rehabilitation registration is different. "These patients are considered series patients with a set of multiple appointments," Logan explains. Thus, these patients do not require full registration each time they present.

Adding to the confusion, the EMR does not indicate when a patient was last fully registered. "The process involves manually checking to see when a patient had a full registration last," Logan says. "That can sometimes get missed."

Employees are not the only ones frustrated by this. "Patients tend to get upset when someone new tries to perform a full registration on them," Logan says. Many patients have been coming in for a week or more without fielding basic demographic questions every time.

To keep skill sets such as these current, employees need exposure to the area at least once every couple of weeks. Scheduling and rehabilitation are the most challenging.

"There are so many little intricacies that these two areas have to keep on top of. It's difficult to remember them all if you are not performing the tasks day in and day out," Logan says.

Rehab scheduling involves multiple appointments scheduled out for weeks in advance. Staff must schedule the correct number of appointments on days that work for the patient and therapist. If an appointment is missed, the therapist's schedule fills up, meaning patients have to extend their rehab out further. "This can impact their recovery and their satisfaction," says Logan, noting that this is where the EMR's auto-scheduling function comes in handy. "It helps us not have to remember every conflict in a department's schedule."

Cross-training helps more than just efficiency; it also boosts morale because employees have better working relationships.

"They all get to know each other a little better this way," Logan says. "They get to help each other in areas where they lack." ■

COMING IN FUTURE MONTHS

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Clinical Areas Often Forget About Patient Access When Making Changes

Sometimes, clinical areas disregard patient access when making changes to policies, procedures, or protocols — until trouble starts.

Peter Kraus, CHAM, CPAR, FHAM, a business analyst for revenue cycle operations at Emory Healthcare in Atlanta, collaborates with clinical areas on projects involving new locations, billing protocols, and report generation. "As with many departments, clinical areas sometimes are unaware of the impact of their operations, policies, and procedures on downstream," Kraus notes, offering two recent examples:

• Clinical areas tested changes to their automated systems without informing patient access.

Clinical systems are updated routinely, which may include new locations or internal fixes that require the registration of test patients.

"Clinical staff may neglect to tell ancillary systems, including those used by patient access and patient accounting, that they've been testing," Kraus says. Clinicians also may fail to use test naming conventions that help identify test patients. This populates not only the clinical systems but also the Admission/Discharge/Transfer and financial systems with bogus patients.

"These become identifiable only after they cause much confusion and extra investigation, not to mention skewing statistics," Kraus notes. These skewed statistics can include census figures, posted charges, or even billed charges if the account slips by the medical records department and is coded. Bogus test patients can affect productivity reporting.

"In fact, test accounts can qualify for all sorts of internal reporting, depending on the nature of testing," Kraus adds.

• When patient-accessible units are renovated or expanded, departments submit their requirements to a central, information services-led team, leaving patient access uninformed.

The team evaluates and updates all the various interfaced online systems that potentially are affected by test accounts in production. This includes clinical systems, registration, billing, collecting, medical records, and financial systems.

"Much later in the project, they will announce big changes, often already implemented, that inconvenience everyone," Kraus says.

This has been especially challenging when nursing units are added or expanded. Typically, these teams submit a list of new locations and room numbers to be built into hospital systems for ordering and reporting purposes.

"They then change everything physically before letting everyone know that systems must be rebuilt," Kraus says. When locations or room numbers change at the last minute, the original additions can be inactivated. "But the extra time and work involved can be significant," Kraus adds.

At Emory, the revenue cycle operations department holds a biweekly meeting to discuss the status of outstanding issues, projects, and system updates. In recent months, nursing and department system managers have been included. "We have become acutely aware of how interdependent we are," Kraus says.

Familiarity with work processes is necessary, but so is camaraderie. "Equally or perhaps more important is friendship and familiarity," Kraus offers. Staff who know and respect each other tend to be more considerate about how planned changes will affect other departments. It turns out that friendship is a satisfaction-booster for patients, too. "Patients pick up on the positive vibes, which enhances their experience," Kraus adds.

Tension fades quickly if patient access "come up with the goods" in terms of must-have information. "I enjoy cordial relations with a number of departments because I supply them with reports containing data they struggle to obtain from other sources," Kraus explains. Some particularly coveted data include information on missing precertification numbers and other prerequisites for admission, patients who qualify for the Two-Midnight Rule, statistics on observation patients, the number and cost of avoidable denials, and statistics on patients treated by specific physicians or groups of physicians (such as insurance coverage information).

Obviously, there can be a fine line between helpful collaboration and taking advantage of someone. "But, generally, the benefits outweigh the extra effort expended," Kraus says. Surprisingly often, patient access responsibilities still are viewed as unimportant clerical work that requires little to no skill. "It's seen as annoying to patients and time-consuming," says **Carol Venson**, financial counseling manager for Novant Health. This is painfully evident when clinicians sometimes remark, *"Is all of this really necessary?"*

To build mutually beneficial relationships, Venson says clinical leaders observe patient access by

shadowing them for a short period. During this time, patient access employees tell clinicians about particularly difficult (and even dangerous) registrations. Examples include duplicate medical record numbers, unconscious patients, and patients trying to use false identities to claim someone else's medical coverage.

Patient access employees explain the "how and why" of insurance verification. They show clinicians how complex benefits are explained to patients. Clinicians can see collection totals and how those affect the hospital's operations. Also, patient access shares statistical data on noncompliance after the fact. After these sessions, clinicians often are shocked by how often registrars are unable to obtain basic insurance or demographic information at a later date.

"We share nightmares associated with patient access not being present or obtaining incorrect information," Venson says. These worst-case scenarios include the inability to bill for services.

But patient safety is a very real concern. Without registration, clinicians are unable to chart on a patient or dispense medication.

"If information is not accurate, there is a risk of misdiagnosis or dispensing medication patients may be allergic to," Venson says. ■

Obtaining Auths Monthly for Physicians Can Lead to Fewer Claims Denials

At first glance, offering to obtain authorizations on behalf of physicians' offices sounds like a lot more work. However, a move like this can benefit the department in more ways than one.

Stillwater (OK) Medical Center implemented a new centralized prior authorization process in 2017. This process is used for 23 clinics that are either owned or managed by the hospital.

"We started with less than 10 prior authorizations the first month. In October, we did over 300," says **Renee Swank**, CHAM, patient access services director.

To start, clinics email the patient's information to a group of prior authorization specialists, who are part of the central registration department. These employees use spreadsheets to track the status of each prior authorization. Once authorization is received, the central scheduling department is notified to call and schedule the patient. The schedulers email or note in the clinic EMR when the patient is scheduled.

"We have had to tailor the process for some clinics that use different EMRs," Swank says. "But it has been a huge satisfier for our physicians." There are fewer claims denials, and registrars are much less stressed. "They are in control of the authorization process," Swank adds.

Previously, registrars were left wondering if the clinic had started the process at all. They were left guessing as to whether the authorization would be received prior to service. Now, there is a strong rapport between clinic staff and prior authorization specialists. "We get requests from new clinics to be added to the process daily," Swank reports.

As of early 2019, Petersburg, WV-based Grant Memorial Hospital's patient access staff is obtaining authorizations for physicians. "We are starting with one clinic, not hospital-owned, as a trial," Patient Access Manager **Anna M. Ours** says. Shortly afterward, the service will be opened to all physician offices.

"The position will be covered by patient access staff," Ours explains. Initially, the department posted the position for a new hire. "But since we are rolling out the program slowly, we decided to use current patient access staff to fill the role," Ours adds. The position was given to the department's most senior scheduler. First, the scheduler contacted insurance companies and physician office staff who currently obtain authorizations.

"We did this to get ahead of the game so that when we had our first request, we would know the paperwork to ask for in advance," Ours says, noting this will eliminate some back-and-forth between patient access and the physicians. "The point of the new department is to make it easier for physicians. If they spent more time assisting us on the phone, then the new process wouldn't be worth it."

Once the request for authorizations increases, the position will be expanded. The full-time schedulers and one part-time scheduler will schedule, preregister, and obtain authorizations. "In the future, we will also work on OBS accounts to get their radiology procedures authorized," Ours says.

A flood of missing and incorrect authorizations motivated Rockledge, FL-based Health First to create an authorization management team in 2011. Frequently, authorizations

provided by physicians' offices were for another procedure, the wrong service date, or the wrong facility. "We now obtain authorizations on behalf of all of our patients when needed," says **Michelle Fox**, DBA, MHA, CHAM, director of revenue operations and patient access.

Change did not happen easily. Patient access staff had to learn each payer's preauthorization requirements. "We needed enough lead time from when the patient was scheduled to the actual service date," Fox recalls. Another challenge was gathering all the required information from the physician's office.

One central phone line and one fax line is available to patients and physicians' offices to request authorizations.

"The call center is available on an equal basis to all patients and physicians, without regard to any physician's overall volume or value of potential referrals," Fox notes.

The department has had a robust preregistration process in place for years.

"'No authorization' denials were not a big problem for us," Fox says. However, when the authorization management team first started, there was an immediate uptick in workflow efficiency.

"Our team did not have to chase down authorizations through numerous phone calls and emails to the physician offices," Fox adds.

Since 2006, Birmingham, AL-based Brookwood Baptist Health used an outside service to obtain authorizations on behalf of physicians and clinics for services performed in the facility. That changed several years ago.

"We initiated a process that allowed us to bring these services in-house," says **Wendy Lepp**, corporate director of patient access.

Patient access had a good relationship with the vendor. "But we needed to be good stewards of our resources," Lepp says. By bringing the services in house, physicians' offices get the same level of attention, but at a lower cost.

"We reviewed several products that would enable this in-house capability," Lepp says. A product was selected that allowed the physicians' offices to provide all the necessary information to obtain authorizations for procedures and tests.

Job descriptions, staffing, space, and software needs all had to be considered when setting up the new precertification department.

"We decided to start with a team of four employees and one supervisor," Lepp recalls. The supervisor also is a licensed practical nurse, ensuring good communication with clinicians.

"When we rolled the product out to physicians' offices, we hosted a series of lunch-and-learns," Lepp says. Patient access gave some one-on-one training to the physicians' offices that elected to use the system.

When the new process started in 2014, about 25,000 requests for authorizations were completed. Demand has surged each year. When the requests hit 35,000, another team member was added. "In 2017, our team completed 42,617 precertification requests with only four denials," Lepp reports.

Offering the precertification service by staff with a very thorough understanding of insurance requirements is a win-win.

"It allows physicians' offices to focus on patient care," Lepp says. "The facility receives payment for services performed with fewer denials." ■

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