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INSIDE

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Revamped Tactics Needed to Overturn Surge of Denied Claims

Just a few years ago, a denied claim was a relatively rare occurrence in the patient access world.

"It was an exception. It seems like it's now become a rule," says **Cynthia Fry**, PhD, senior vice president of revenue at Philadelphia-based Thomas Jefferson University & Jefferson Health.

Many denied claims give not just one reason for nonpayment, but several. Initially, the claim is denied for requests for medical records, which are sent. Then, the claim is denied again for lack of medical necessity. "We will get multiple denials that drag out and unfavorably impact our accounts receivable aging," Fry laments.

Forced to invest significant resources trying to overturn all these denials, patient access departments are searching for the most efficient and effective way to do it. "All denials are worth appealing because we rendered the service and deserve to be paid," Fry argues.

At Hennepin Healthcare in Minneapolis, "denials are more prevalent than ever before. Just look at the volume of vendors who have denial management solutions," says **Phillip E. Brooks**, vice president of revenue cycle.

Revenue cycle departments "are in the business of submitting claims for services rendered in an effort to receive reimbursement," Brooks says. "Insurance companies kind of play games. There are all kinds of shenanigans that go on." Here are some effective tactics to overturn unfairly denied claims:

- **Prove claims were denied because payors had not updated their systems to reflect the new coverages patients selected.** At the time patient access staff verify insurance, everything looks good. When the health plan's system is updated later, it turns out the patient was not eligible after all. Those claims are denied, a problem that has grown worse during the COVID-19 pandemic. "With COVID, the payors have experienced staffing issues just like everyone else has," Brooks observes.

To overturn the denials, the department tracks the date claims were submitted and the payor's response.

- **Scrutinize the language in payor contracts.** "Sometimes, the insurance company is not adhering to their own rules, and the payer denies," Brooks notes.

Referring to the terms that were not met, such as specific timeframes to give a response on authorizations, can overturn some denials.

- **Track denials caused by glitches with payors' own systems.** One payor's system will not allow staff to electronically

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SUBSCRIBER INFORMATION:
(800) 688-2421
customerservice@reliasmedia.com
ReliasMedia.com

AUTHOR: Stacey Kusterbeck
EDITOR: Jonathan Springston
EDITOR: Jason Schneider
EDITORIAL GROUP MANAGER: Leslie Coplin

attach operative notes to surgery claims. "In not being able to do so, [the claim is] denied automatically," Brooks says.

Staff must send the operative notes by fax or mail instead. "This is antiquated, and what does that do? It delays things," Brooks adds.

Other payors operate with inadequate resources to manage the number of claims submissions they receive. "It seems like they have only one fax machine, and you are limited to the volume of documents you can send," Brooks reports.

Overturning these denials really cannot be addressed by frontend staff. It requires involvement from revenue cycle experts. "Sometimes, the only way to get that resolved is to have a one-on-one meeting with the payor," Brooks offers.

• Move balances from the primary or secondary payor to secure payment. "Coordination of benefits is always a big issue and very complex at times," Brooks explains.

• Identify denials caused by alleged failure to meet the payor's overly stringent time requirements. Some claims are denied because they are submitted just one day late; staff was holding off to make certain all the information was correct. "We bill it out, then the insurance says we had 45 days, and we are at day 46. That one drives me crazy," Brooks says.

The department employs two denial analysts who spot those kinds of trends quickly. "We look at what can we fix, and what can we have the payor fix," Brooks says.

• Expand the definition of what constitutes a denial. "We review all underpaid claims as well as unpaid ones," Brooks says.

• Identify the specific clinical standards health plans use. "Our vendors who provide denial management solutions talk about how insurance companies are always walking a fine line between reimbursement and in practicing medicine," Brooks says.

While total knee replacement always was reimbursed on an inpatient basis, some payors now reimburse for the procedure only on an outpatient basis. Likewise, certain payors deem some procedures experimental, but not others.

Some payors are even adding specifics about which brand of skin grafts they will pay for. One recent skin graft was denied because the payor excluded the specific brand used in the procedure. "We had been billing for it for years, and always got reimbursed," Brooks recalls. "The patient received a huge bill, and understandably was miffed."

Overturning denials has become a full-time job for many revenue cycle employees. Jefferson Health started a denial prevention and recovery initiative in 2020. "On the prevention side, we collaborate with patient access and care management," Fry explains.

The recovery side is handled by the business office's newly created 14-person denial team. "Some denials you can overturn easily. Others are much more difficult," Fry notes.

About 20 employees at Hennepin Healthcare now handle denial management, with a pretty good track record. "But the amount of resources spent on overturning denials has to make sense. If you are spending $49 to get $50 of reimbursement, it's not worth it," Brooks cautions.

On the other hand, hospitals want to receive every dollar of revenue to which they are entitled. "In some places, if the denial is less than a certain dollar threshold, they don't go after it. That is not the methodology we use," Brooks reports.

The department takes the attitude that the health plan agreed contractually to pay for healthcare, and that the hospital deserves to be paid. It does

not always work. The toughest denials are noncovered services. "That is a hard denial that they are just not going to pay no matter what you do," Brooks laments. Considering the surge in volume of nonpayment of valid claims, more pushback probably is in order at this point.

"You have to meet with payors and hold them accountable. Alternatively, the insurers will hold us accountable," Brooks says. ■

Denials Categorized Based on Complexity

Some denials can be overturned easily — maybe a piece of clinical documentation is missing. Other denials are a long shot, requiring lots of time and effort to challenge. "We work all denials. Nothing goes untouched," says **Cynthia Fry**, PhD, senior vice president of revenue at Philadelphia-based Thomas Jefferson University & Jefferson Health.

To better understand the recovery rate and effect on receivables, the department uses three tiers to categorize denials:

Tier 1. These are complex denials and are the hardest to recover.

Some are medical necessity denials in which clinical documentation was sent already, meaning it is not a simple matter of providing the clinicals. "The payor has already reviewed them, and determined the service wasn't medically necessary," Fry says.

Other examples of tough denials are claims that were downgraded from inpatient status to observation status. "We assign a collectability percentage — an overturn rate — based on what tier the denial falls in and how old the denial is," Fry says.

The older the claim, the harder it is to collect. For Tier 1 denials, the team produces a 20% to 30% recovery rate early. As time passes, that percentage drops even lower. The department still tries to overturn these denials. "But it's very hard to win an appeal if the documentation does not support medical necessity," Fry adds.

Tier 2. These denials "are in the middle of the road," Fry explains.

Most are registration-related, and do require some effort from outside the department. Some involve coordination of benefits, where staff have to engage with the patient to secure a signature on a form.

Other examples of Tier 2 denials are eligibility and noncovered services. "There's about a 75% success rate early on. But as they age, the percentage drops," Fry notes.

Tier 3. These include billing-related denials, coding-related denials, and information requests, with a 90% overturn rate.

"These denials are the easiest to overturn, and have high rates of successful appeals," Fry says. ■

Surprise Bill Legislation Means Big Changes for Patients and Hospitals

Some people experiencing life-threatening symptoms put off coming to the ED for a strange reason — they were stuck on the phone with their health plan.

"I have seen people have bad outcomes because of waiting too long to come in because they were trying to find out which hospital was in-network," says **Bradley J. Uren**, MD, FACEP, chair of the American College of Emergency Physicians federal government affairs committee.

Certain patients might experience heart attack symptoms for hours. Instead of going to the ED immediately, they called their health plan. "That should never be something that someone should be concerned about when they have a life-threatening condition," Uren says. "People should have the confidence that they can go to an ED — any ED — and get the care that they need."

Many people have heard horror stories from friends or family about the financial toll of an ED visit — or, at a minimum, are aware of the problem because of news coverage. "This has been in the public consciousness for a while," Uren notes.

It is not just out-of-network status causing huge bills. Many stem from insurance paying little despite the visit's in-network status. "The 'surprise' is often that you didn't have the insurance coverage you thought you had," Uren observes.

Many insured patients are hit with high copays, deductibles, or coinsurance, which can result in astronomical bills. "They remain in network, but the insurance doesn't cover what they thought it would," Uren says.

Patients or family members might try to be proactive about the situation. Patients ask if the treatment ordered by the emergency physician (EP) was something that needed pre-authorization from their insurance

company. Others express concern that if they do not secure advance permission from their insurer for the test, procedure, or admission, they may face a large bill later.

"Even if I knew what someone's insurance was, it's not possible to figure out in real time what they will owe," Uren explains.

It is impossible to predict which diagnostic tests, lab tests, or level of care are going to be needed, or which providers (surgeons, cardiologists, or others) are going to be involved. "In many cases, we just can't provide that insurance granularity at the time of care," Uren says.

Patients might hesitate to go through with the recommended evaluation specifically because they are worried about cost. This requires a difficult conversation between the EP and the patient (i.e., why the exact dollar amount that will be covered by the health plan just is not the priority at the moment).

"An explanation is needed on why I don't think we should delay care to look at those things. Because at that point, insurance is not the most important thing, their life is," Uren says.

Uren puts it this way: "This is the test that the best evidence says should be ordered. If it was one of my family members, this is the test I would want for them. We will do everything we can to work with you on the back end, but this is the care I believe you need right now."

Most patients appreciate the honesty, and agree to the recommended testing. "Some do choose to refuse testing or treatment despite medical advice, citing persistent concerns about large copays or uncovered expenses," Uren adds.

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the Consolidated Appropriations Act of 2021. The No Surprises Act addresses surprise bills at the federal level, and will go into effect Jan. 1, 2022.[1] Among other things, the legislation will ensure that if out-of-network care is provided, the patient's cost will be the same as if the provider was in-network.

"Implementation of the act will likely add another layer of complexity to revenue cycle processes," says **Helaine I. Fingold**, JD, a healthcare attorney in the Baltimore office of Epstein Becker Green.

A few states have enacted laws to protect enrollees from surprise billing. These existing laws apply to fully insured plans, and will continue to apply under the new law. "The No Surprises Act will add self-insured plans to the surprise billing mix," Fingold explains.

For self-insured plans, revenue cycle departments will need to identify affected out-of-network services, calculate cost-sharing and payment amounts based on the plan's average contracted rate, and manage the dispute resolution process, through which out-of-network hospitals can seek higher payment amounts. "Each of these steps will require a defined business strategy," Fingold says.

The best approach is going to vary depending on the health plan. For instance, some plans will take the approach of making an initial payment that is below the average contracted rate. The nonparticipating hospital that provides ED services to an insured patient can either accept that payment amount or push for a higher payment using the dispute resolution process. "The No Surprises Act does not provide protection for all services received out of network," Fingold notes.

It only protects enrollees from receiving a surprise bill for emergency services provided by a nonparticipating provider at either an in-network or an out-of-network facility, or for certain nonemergency services provided by a nonparticipating provider at an in-network facility. "It does not cover, for example, services provided by a nonparticipating physician or practitioner in a physician's office or other nonhospital clinic," Fingold explains.

A patient still could receive a surprise bill for covered nonemergency services from a nonparticipating provider outside the hospital setting. "The new law should not result in hospitals having to write off entire bills for emergency services," Fingold says.

However, for out-of-network ED care, hospitals might have to write off the difference between billed charges and the approximate amount they would have received had the hospital been in network. In states without surprise billing laws, hospitals can use the new law's negotiation and arbitration processes to seek higher reimbursement amounts.

"Ultimately, facilities will need to assess the cost of bringing such challenges to determine the viability of operating out of network as a business strategy," Fingold says.

From the patients' perspective, the legislation is at least somewhat reassuring. Yet people are likely to remain anxious about surprise bills. "Bad news travels fast, and good news travels more slowly," Uren says. "It's a major problem, and it will take years to unwind the anxieties that have been created."

Revenue cycle staff still need to alert patients about the possibility of a surprise bill. "But to the extent that this law can take patients out of the middle, I'm pretty happy with that," Uren reports. ■

REFERENCE

1. American Hospital Association. Detailed summary of No Surprises Act. Jan. 14, 2021. https://bit.ly/32UoRMu

In 5 Minutes, Patient Access Can Stop Lost Medicaid Coverage

The problem of Medicaid coverage disruption is well-documented, and it happens for many reasons.[1] Sometimes, it is because the person is homeless.[2]

Researchers analyzed Medicaid claims data from 2017. They found 22.9% of patients with a homelessness code experienced coverage interruption at least once vs. 18.8% of Medicaid patients without a homelessness code. **Gerry Baker**, MBA, senior vice president for revenue cycle at Parkland Health & Hospital System in Dallas, says there are some other common reasons people lose their Medicaid coverage: income changes, residency changes, the insured is no longer pregnant, the insured's children age out, noncompliance with status updates, or the insured is no longer disabled. "If SSA [Social Security Administration] or the state loses track of the people, they often will terminate the Medicaid," Baker says.

If a patient is in this situation, registrars help him or her contact SSA. Often, this action alone is enough to reinstate benefits. "We assist with providing missing updates with new applications for Medicaid and with renewing or reinstating Medicaid coverage," Baker says.

Meera Mani, MD, PhD, partner and leader of McKinsey & Company's Medicaid work, explains preventable coverage disruptions occur because members do not realize they had to renew (or when to do so), and miss the deadline. Also, members might struggle to submit all required documentation. Patient access staff can help people keep their Medicaid coverage by explaining the process. "This can have a positive impact in limiting coverage disruption for eligible beneficiaries," Mani says. Coverage loss often happens at the point of renewal. "Most states approach it from an old school perspective and mail out a notice," says **Jennifer Wagner**, director of Medicaid eligibility and enrollment at the Center on Budget and Policy Priorities.

The person has to receive the notice, understand it, complete it, and send it back on time, sometimes with pay stubs or other proof of income. "That is a very challenging process for a lot of people, and it leads to a lot of eligible people losing coverage and having to reapply," Wagner reports.

Other times, the problem is just a bad address. Notices are returned as undeliverable, causing loss of coverage. Some states bypass this issue with automatic renewal processes, based on information from available databases without the need to send paper documents.[3]

With automatic renewals, the client receives a notice that benefits have been renewed, but does not have to respond to the notice. "A lot of states don't take full advantage of that process and have overly restrictive rules. A handful of states don't do it at all," Wagner laments.

Right now, most Medicaid coverage disruptions are on hold thanks to exemptions under the Families First Coronavirus Response Act. These are expected to last through 2021. After that, states will have to catch up on a large number of renewals. "There's a huge risk that people will lose coverage at that point," Wagner cautions.

To protect against lost revenue, patient access staff could help patients reapply for Medicaid to obtain retroactive coverage. "But it's a lot more hassle for everyone involved to reapply. The person may have forgone treatment or prescriptions while they had a gap in coverage," Wagner observes. Right now, there is a chance for states to avoid all this by automatically renewing as many patients as possible. "People aren't losing coverage right now. But it's an opportunity to get things in place so people won't lose coverage when the public health emergency ends," Wagner offers.

As for what revenue cycle departments can do to help, it depends somewhat on how much front-end staff can see in the state system. In some cases, there might be a way for the hospital to submit updated addresses for the patient, or at least log onto the state portal so the patient can update the address. This simple intervention can prevent coverage notices from going to an old address. "If there is somebody who can sit face to face with someone and help them through that process, that's significant," Wagner says.

Patient access staff can look at the state's Medicaid Management Information System to see if there is active coverage. Some states also show the renewal date. "Many people don't realize what the cycle is and when they are due for a renewal," Wagner says.

The implications for patients go beyond just obtaining health coverage. "Some states have combined applications that allow people to apply for Supplemental Nutrition Assistance Program (SNAP) at the same time as Medicaid," Wagner notes. If so, registrars can help patients download the mobile app or log onto the online portal. "Sometimes, five minutes of handholding can get someone over the initial hurdle of setting it up," Wagner says. "It is very valuable, with minimal extra effort."

Short-term interruptions in SNAP benefits resulted in differential patterns of healthcare utilization, according to a recent study.[4] Researchers found half the SNAP population experienced a short-term interruption in their benefits and that it happened more often for women, African Americans, and young patients. Those with SNAP disruption logged fewer outpatient visits, ED

claims, and prescription drug claims, but more inpatient claims. "This is exactly what you might expect if patients are making trade-offs between food and healthcare. It suggests that the trade-off had negative health consequences requiring acute care," says **Colleen Heflin**, PhD, the study's lead author and a professor of public administration and international affairs and a senior research associate in the Center for Policy Research at Syracuse University. In light of this finding, hospital-based financial counselors could consider asking patients about their SNAP coverage to help them remain on the program. "It may be that some patients lose SNAP benefits during periods of hospitalization because they are unable to complete the required paperwork during acute health events," Heflin notes. ■

REFERENCES

1. Sugar S, Peters C, DeLew N, Sommers BD. Medicaid churning and continuity of care: Evidence and policy considerations before and after the COVID-19 pandemic (Issue Brief No. HP-2021-10). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. April 12, 2021. https://bit.ly/3eA7plV
2. Dapkins I, Blecker SB. Homelessness and Medicaid churn. *Ethn Dis* 2021;31:89-96.
3. Wagner J. Streamlining Medicaid renewals through the *ex parte* process. Center on Budget and Policy Priorities. March 4, 2021. https://bit.ly/3ev3o2a
4. Heflin C, Hodges L, Ojinnaka C. Administrative churn in SNAP and health care utilization patterns. *Med Care* 2020;58:33-37.

Simple Changes Cut Wait Times in Registration Areas

Delays can be caused by slow registrars, the need for interpreters, too many patients scheduled at the same time, or talkative patients, among many other things, says **Mindy Grubbs**, patient access manager at Novant Health Kernersville (NC) Medical Center and Novant Health Clemmons (NC) Medical Center. Patient access leaders tackled all these issues and more to cut wait times. "Some save more time than others, but all are a factor," Grubbs says.

• Managers added more registrars during the busiest times. "We also added team members when a new service was added," Grubbs reports.

• Review the next day's schedule for missing orders or Advance Beneficiary Notices (ABNs) that need to be corrected. "Getting this taken care of prior to the visit means there is no need to call physicians at the time of service," Grubbs says. Registrars check that all the patients scheduled for the following day have an order attached. If not, registrars call the doctor's office to request it. It is a big time-saver for patients.

"Requesting an order can take an hour or longer in some cases," Grubbs notes. As for ABNs, registrars look for incorrect diagnosis codes the physician entered. "If we catch these the day before, we can request that the doctor correct the order," Grubbs says.

• Save time when asking patients for ID and insurance cards. Registrars first look in the chart to see if it is in the system. If the registrar does need to ask for the ID and insurance card, the registrar proceeds with the registration while the patient is looking for it, which saves a minute or two.

• Added e-check notifications to the registrars' screen. If the patient already checked in online, staff know the entire registration process does not need to be completed.

• Registrars no longer tell patients about next steps with their surgeries. "This is the same information that the nurse tells the patients," Grubbs explains. "This can be eliminated, and is not the responsibility of patient access." Registrars also were asking COVID-19 screening questions, even though patients had just been asked those same questions when entering the facility. "This step can be bypassed," Grubbs says.

• Team members no longer ask patients to wait in their office if there is an issue that needs follow up. Some patients are add-ons and need an order from the physician's office. If so, the registrar asks the patient to go to the waiting area. Securing the order "can take some time, and delaying the next patient is not the correct process," Grubbs says.

• Registrars know what to do if there is unexpected down time. "Team members know how to handwrite armbands if the printer is down, or make copies of forms if the scanner is not working," Grubbs reports.

• Registrars are discouraged from talking too much. "We explain to the team member that continuous conversation is keeping the patient from their appointment," Grubbs says.

• Guest services escort patients to procedures instead of registrars. "We have a space that we ask patients to sit in so guest services know they are ready to be walked to the next area," Grubbs says.

• Regardless of the wait time, registrars are up front about it. "If you know that the patient will have to wait an hour to be seen, let them know," Grubbs says. "They may want to leave and come back." ■

Revamped Processes Prevent Admission Notification Denials

Some patients clearly meet the medical criteria for a hospital admission. Despite this, the health plan refuses to pay the claim — because staff did not notify the health plan soon enough.

At Maury Regional Medical Center in Columbia, TN, several recent claims involving direct admissions were denied. All patients had come through the ED, were evaluated, and were moved to the observation unit. The patients were discharged, but returned to the hospital later on the same day and were admitted. The precertification staff had signed off on the observation stay.

"When the patients returned for direct admissions later that day, our precert team did not get the alert they normally would have to ensure authorization was reviewed at the time of service," says Preservice Manager **Jennifer Smith**.

All the claims were denied because of failure to timely notify the health plan of the admission and obtain the required authorization. "When I was made aware of these denials, I identified an area we could improve on to ensure situations like this did not occur again," says Smith, who explains the new process:

• The admissions department alerts the inpatient precertification team of direct admissions. This ensures timely review of the patient's chart so it can be financially cleared.

• The precertification team reviews all ED discharge documentation. Depending on the patient's status (either admitted or discharged home), staff take one of two actions to financially clear the account.

For patients who were admitted, staff contacts the insurance company to review requirements for authorization, medical necessity, and observation or inpatient status.

For patients who were discharged, the team notifies the health plan of the date of discharge, and whether the patient was discharged home or to another facility.

"With this slight adjustment to our process, we have not seen further denials related to direct admissions after discharge," Smith reports.

Issues with timely notification also were happening for obstetric patients. In some cases, mother and baby were scheduled to be discharged, but the baby ended up in the neonatal ICU.

"The precertification team wasn't notified of the change, so they failed to notify the insurance timely," Smith says.

The health plan refused to pay the claims. To prevent this from happening again, the admissions team now immediately alerts the precertification team of the unexpected admission.

At Sharp HealthCare in San Diego, patient access staff put in some new processes to avoid "failure to notify" denials. Staff now work in close proximity to bedside placement nurses. "As they are clinically placing the patient, we are financially clearing the patient," says **Kristin Harold**, manager of access services.

Patient access notifies the payor about the admission right when the patient is placed into a bed. Pop-ups on the registration system alert staff if the health plan has any specific requirements, such as using a certain fax number. "We work very closely with our payor relations and contract team to notify payors in real time, or as close to it as possible," Harold explains.

In acute care, the situation can change rapidly. At 2 p.m., the patient could be in observation status. By 5 p.m., inpatient-level care is needed. "In an effort to mitigate that, we try to do a dual notification," Harold notes.

That process was quicker and easier when several payors were accepting electronic notification. "They have since gone to a portal method instead, so we don't have any integrated notification," Harold laments.

All admission notifications are now handled manually. As soon as the patient is admitted, staff faxes the information or enters it in the payor's portal. Most health plans require it to be handled within one business day. That means if the patient is admitted on Friday afternoon and Monday is a holiday, there was a backlog of several days' worth of patients on Tuesday. "We did have some untimely notification of denials," Harold says.

Previously, bed placement was managed independently at each of Sharp HealthCare's six hospitals (five acute care and one behavioral health). Five years ago, a centralized patient placement unit was implemented.

"We are now simultaneously financially clearing and submitting for any precerts that are needed," Harold says.

To avoid delays, staff conduct admission notifications 24 hours a day, seven days a week, as soon as the patient is in the bed. However, a new problem has emerged. After discharge, payors are disputing the level of care, claiming the patient did not need to be hospitalized. Some use length of stay to deny payment.

"We have one payor in particular that pushes back against any admission that's less than two days, and says it is not inpatient," Harold shares.

If a payor disagrees with the level of care assigned, a peer-to-peer discussion happens between the health plan physician and the patient's physician.

"The other thing we have done is build some tools to trigger alerts,"

Harold says. If an admission notification is somehow missed, staff fix it before the claim is sent. Likewise, staff are alerted if a fax number changes or a payor makes changes to the portal. "That's the key, to make sure we get the information sent to the right people at the right time," Harold says. With all these changes, the department has cut "untimely notification of admission" denials to near zero.

"We are at 0.002% of our total patient volume in the last year," Harold reports. ■

Case Managers Help Resolve Inpatient Claims Issues

Admission notification denials are no longer happening at Moffitt Cancer Center in Tampa, FL, thanks to collaboration between patient access and case managers. "We are not experiencing denials due to this issue. We have a robust submission and follow-up process," reports **Viviana Beland**, director of the financial clearance unit.

For urgent admissions, payors allow notification on the next business day. For planned admissions, authorization must be secured before admission. "We use worklists that are created for inpatient encounters only. It allows the team to easily identify the inpatients, and keep those separate from outpatients," Beland says. It also prioritizes the workload. "Every single patient in the worklists is worked before the end of the day," Beland adds.

Sometimes, there is just no time to wait. For urgent surgical cases, care proceeds with the authorization in "pending" status. The health plan is determining the status (outpatient or inpatient). "We proceed with the surgery as outpatient status," Beland says.

Once the surgery is finalized and the patient meets inpatient status, case managers become involved. They contact the health plan's utilization review department to justify the need to admit.

"They have a clinical discussion with insurance company after surgery, but before the admission," Beland says. "Since admission meets medical necessity, we get an approval."

At Children's Hospital Colorado in Aurora, patient access has been successful proving medical necessity with the help of case managers.

"Over the past year, we have done a ton of work around defining role clarity," says **Suanne Kindel**, operations manager of patient access and financial counseling.

Each revenue cycle area plays a different role in financially securing every inpatient visit. "We mapped out each direct admit process. It became clear that the inpatient workflow is very complicated, like a big maze," Kindel reports.

Previously, the department's weekly meetings focused on high-dollar accounts. Now, they cover scheduled admissions and other inpatient cases. "We can now be proactive with case management," Kindel says.

This helps when a patient comes through the ED, and registrars cannot obtain insurance information at arrival. "This can cause delays in notification and sending clinicals," Kindel notes.

It has become clear that a strong working relationship among case management, patient access, insurance verification, billing, and financial counseling is critical. "We now have the ability to be proactive when an insurance will not cover an inpatient stay," Kindel adds. ■

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HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Right of Access Settlements Yield Lessons, Insight on OCR Approach

With nearly 20 settlements so far, the Office for Civil Rights (OCR) is showing its determination to protect patients' rights to obtain their medical records from healthcare entities.

OCR announced its Right of Access Initiative in 2019 and vowed to "vigorously enforce" patients' right to access their medical records. OCR continues investigating allegations of improper delays that potentially violated the HIPAA Privacy Rule's right of access requirements (45 C.F.R. § 164.524).

Former OCR Director Roger Severino said in November 2020, "We will continue to prioritize HIPAA Right of Access cases for enforcement until providers get the message." There have been seven more settlements since then.[1,2]

Lessons from Settlements

A key takeaway from the 18 Right of Access settlements is that providers cannot ignore OCR investigations, says **Elizabeth Litten**, JD, partner and chief HIPAA privacy & security officer with Fox Rothschild in Princeton, NJ.

"If a patient complains and OCR investigates, the provider must do whatever it can to provide the requested records to the patient as quickly as possible," Litten says. "Many of the settlements involve situations in which the provider failed to provide the complainant's records even after the OCR began an investigation and provided 'technical assistance' designed to facilitate the provider's compliance."

Risk managers and compliance officers can learn from the Right to Access settlements, says **Daniel Hernandez**, JD, partner with Shutts & Bowen in Tampa, FL. He notes all the settlements resulted from a consumer complaint, typically after months of the consumer trying to access records. Healthcare entities must respond in 30 days (or 60 days, if there is a reason to justify the extension).

"If you communicate with these patients when you're having difficulty locating the records or producing them in the format the patient has requested, I think most patients will understand and agree to a longer period," Hernandez says. "Most of the settlements come after not just one complaint but a second complaint. There is an initial complaint to OCR, OCR reaches out to the healthcare facility to say there is a complaint and let us help you facilitate the production of these records with technical guidance, but still the records are not produced, and there is a second complaint."

If OCR pursues a settlement after just one complaint, the lapse of time between the first request and the complaint has been significant.

"It's not as though the hurdles for complying are insurmountable. The healthcare facilities have these records, and the settlements are not coming as the result of technical violations of HIPAA, such as providing the records in an incorrect format, providing them to the incorrect person, or charging too many fees," Hernandez says. "These settlements come from just not producing the records on a timely basis. If healthcare facilities did that, they would not find themselves in this situation."

Create Policies, Train Employees

Healthcare organizations should make sure they maintain written policies on right of access and train employees on how to respond to records requests. Hospital leaders may have a firm grasp on what HIPAA requires in this regard, but frontline employees responding to

record requests may not understand the requirements or the potential consequences of not responding.

"They need to understand that when there is a complaint, they need to jump on it right away," Hernandez says. "They cannot ignore the patient's request or the complaint about a slow response. I think the problem is a lack of training in many facilities."

Often, hospitals have not created a good process for tracking records requests, so they become lost in a stack of other documents on some employee's desk. "It's not so much a matter of saying no to the request but rather the request gets lost in the system. If the patient doesn't follow up and make multiple requests, nothing happens," Hernandez says. "Sometimes, even when the patient does make repeated requests, nothing happens." Hernandez notes all the recent settlements include a corrective action plan, which brings continued scrutiny after the fine is imposed.

The requirements of the plans are straightforward and derived from HIPAA — the same procedures hospitals should have been following in the first place. A corrective action plan means OCR will be watching closer.

"The enforcement mechanisms available to OCR are unique and have significant teeth to them," Hernandez says. "I don't get the sense that the average person at a hospital who works in the front office has a good appreciation for the potential consequences of not giving a patient his or her records in 30 days. They think the only potential consequence is that the patient will get a little upset but eventually they'll get their records and everything will be fine."

Those employees should be educated on the size of the fine OCR could impose on the hospital, and the possibility that such a fine could result in termination for the responsible employee.

"With that knowledge, I think they would be more cognizant and more responsible," Hernandez says. "Educating staff on the seriousness of this rule and the potential consequences would address a lot of the problems you see here." ■

REFERENCES

1. HHS.gov. OCR settles eleventh investigation in HIPAA Right of Access initiative. Nov. 12, 2020. https://bit.ly/3gEeRz0
2. HHS.gov. OCR news releases & bulletins. https://bit.ly/3nqLAJM

Busy Year for Right of Access Settlements in 2021

The Office for Civil Rights (OCR) announced its 18th settlement of an enforcement action in its HIPAA Right of Access Initiative on March 26.[1]

The settlement involved Village Plastic Surgery (VPS) in Ridgewood, NJ, which agreed to take corrective actions and pay $30,000 to settle a potential violation of the HIPAA Privacy Rule's right of access standard.

The case stemmed from a September 2019 complaint alleging VPS "failed to take timely action in response to a patient's records access request made in August 2019," HHS says. OCR's investigation determined VPS' alleged delay was a potential violation of the HIPAA Right of Access standard.

VPS sent the requested records to the patient after the OCR investigation.

In an earlier settlement announced Feb. 10, Renown Health, a private, not-for-profit health system in Reno, NV, agreed to take corrective actions and pay a $75,000 fine — for a single alleged violation.[2]

"In February 2019, OCR received a complaint alleging that Renown Health failed to timely respond to a patient's request that an electronic copy of her protected health information, including billing records, be sent to a third party," HHS reports. "OCR's investigation determined that Renown Health's failure to provide timely access to the requested records was a potential violation of the HIPAA right of access standard. As a result of OCR's investigation, Renown Health provided access to all of the requested records." In addition to the hefty fine, Renown Health agreed to two years of monitoring as part of a corrective action plan.

On Feb. 12, OCR announced a settlement with Sharp HealthCare, which operates four acute care hospitals, three specialty hospitals, three affiliated medical groups, and a health plan in California. The settlement included a $70,000 fine and a corrective action plan with two years of monitoring.[3]

A patient claimed Sharp failed to respond in a timely fashion to request directing that an electronic copy of protected health information be sent to a third party.

"The OCR provided Sharp with technical assistance on its alleged failure to provide access to the records and requested that Sharp respond to the patient's request. In August 2019, the OCR received a second complaint from the same patient alleging that

Sharp still had not responded to the patient's records access request," HHS reports. "The OCR investigated the matter, and Sharp provided access to the requested records."

At press time, OCR had settled five Right of Access investigations so far in 2021, four of those since President Biden was sworn in to office on Jan. 20. ■

REFERENCES

1. HHS.gov. OCR settles eighteenth investigation in HIPAA Right of Access initiative. March 26, 2021. https://bit.ly/3sUm9kE
2. HHS.gov. OCR settles fifteenth investigation in HIPAA Right of Access initiative. Feb. 10, 2021. https://bit.ly/3tTqVQT
3. HHS.gov. OCR settles sixteenth investigation in HIPAA Right of Access initiative. Feb. 12, 2021. https://bit.ly/2PrsCpK

Whistleblower Exception Allows Reporting HIPAA Violations with PHI

Healthcare professionals can find themselves in a quandary when they want to report fraud or other concerns within their organizations because doing so could require disclosure of protected health information (PHI). That could seem like a HIPAA violation; fortunately, there is a whistleblower exception that covers this scenario.

A major goal of the HIPAA Privacy Rule is to ensure an individual's health information is properly protected while still allowing the normal flow of health information needed to provide and promote high-quality care, says **Layna Cook Rush**, CIPP/US, CIPP/C, shareholder with Baker Donelson in Baton Rouge, LA.

Many provisions in the Privacy Rule are designed to strike a balance that permits important uses of information while still protecting patient privacy. The Whistleblower Exception is one of these provisions. This exception is intended to allow the disclosure of patient information to protect patients, healthcare workers, and even the public — but there are restrictions on its application.

The Whistleblower Exception states that a covered entity, such as a physician or hospital, is not considered to have violated the HIPAA Privacy Rule if a member of its workforce or a business associate discloses patient information. This, provided the workforce member or business associate believes in good faith the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards. Or, the care, service, or conditions provided by the covered entity potentially endanger patients, workers, or the public. *(Read more about the exception at this link: https://bit.ly/3dV2Fs9.)*

"Additionally, the disclosure must be to either a health oversight agency or public health authority authorized to investigate or to an attorney retained by the workforce member or business associate to determine the legal options of the workforce member or business associate," Rush says.

The Whistleblower Exception can be used by a workforce member, which can be an employee, volunteer, or even independent contractor, or by a business associate of a covered entity. The disclosure must be made to an oversight agency or to an attorney who is assisting the individual in determining his or her legal options.

The Whistleblower Exception allows an individual to disclose concerns about issues such as billing fraud or compliance issues by using PHI to make the case, says **Christina M. Kuta**, JD, an attorney with Roetzel & Andress in Chicago.

"They can disclose this to an accrediting body, an insurer, other enforcement agencies, or even an attorney they have hired to represent them if they have a good faith belief that there is an issue that needs to be explored," Kuta says. "Once you have that good faith belief, you are allowed to gather information that you wouldn't otherwise be able to gather from the covered entity or the business associate. This could mean printing out patient records or billing statements, things that otherwise you likely would not have a legitimate need to access and certainly wouldn't be allowed to share with third parties."

Under the Whistleblower Exception, the individual can provide that PHI to another party without fear that accessing and disclosing that information will be deemed a HIPAA violation, as long as the necessary requirements are met.

The biggest risk concerns the good faith belief, Kuta says, because there is no objective way of determining that. If a nurse overhears two coworkers talking about how they incorrectly billed a patient, is that enough to conclude they are overbilling many patients, obtain PHI that might prove

the allegation, and send it to the government or a lawyer?

Maybe not. The nurse might have overhead discussion of one error the coworkers were correcting. That might not constitute good faith belief. Accessing and distributing PHI on that alone could be a HIPAA violation not protected by the Whistleblower Exception.

Another pitfall is obtaining and distributing too much PHI to report a concern.

"If you have a concern that the facility or practice is upcoding for one particular procedure, you can't take all the records from the department or from that physician practice and give them to a lawyer," Kuta says. "A lot of patient information there has nothing to do with the fraud you're alleging. Disclosing that information is a HIPAA violation. It wouldn't qualify for the Whistleblower Exception because it is not related to what you're whistleblowing on."

If patient information is used to report a covered entity to an oversight agency, the "minimum necessary" rule still should be used.

"The minimum amount of information necessary to accomplish the intended purpose should be disclosed. For instance, if the patients' names and addresses are not necessary for the oversight agency's investigation and the names and addresses can be redacted from the records being disclosed, then they should be," Rush says. "If the data can be deidentified such that all patient identifiers are removed, then the data should be deidentified before it is disclosed."

There is a good faith requirement in the Whistleblower Exception. It cannot be invoked except when there is a legitimate belief the covered entity is engaging in activity that could be detrimental to patients, workers, or the public. It should not be used as retaliation or for personal gain. For example, an employee who has been terminated cannot take patient information to use in a wrongful termination lawsuit against the covered entity.

"Also, whistleblowers should be very careful about how they disclose patient information and how much they disclose. Courts have sanctioned whistleblowers who placed patient information in the court's public record without sealing or redacting the information," Rush says.

The Whistleblower Exception allows a whistleblower to share information with his or her attorney for the purpose of evaluating legal options. Someone contemplating disclosing patient information as a whistleblower should consult with his or her legal counsel to determine whether a covered entity has engaged in conduct that should be reported to an oversight agency, the amount of information that needs to be disclosed to allow the oversight agency to investigate, and the appropriate agency to which the disclosure should be made.

The Whistleblower Exception protects a covered entity from being considered to have committed a breach if the whistleblower is a member of the covered entity's workforce and is the victim of a crime, says **Arielle T. Miliambro**, JD, partner with Frier Levitt in Pine Brook, NJ. However, the PHI disclosed must be about the suspected perpetrator of the criminal act and is limited to the information necessary to identify and locate the perpetrator.

"For example, an employee who has been assaulted by a covered entity's patient may evaluate, and perhaps ultimately use, this exception to report the assault to appropriate authorities without violating the patient's privacy rights under HIPAA," Miliambro says. "Although the requirements of the Whistleblower Exception have certain flexibility based upon a good faith standard, the requirements must be met precisely as set forth."

Miliambro says it is important to note the covered entity remains, at all times, responsible for the use of PHI by its employees and business associates, even when those individuals attempt to disclose PHI pursuant to the Whistleblower Exception. Therefore, a covered entity may be in breach of HIPAA, and thus exposed to liability, if an employee or business associate impermissibly relies on the Whistleblower Exception to disclose PHI.

A concern for both employer and employee would be that the whistleblower would disclose PHI to either an individual or entity not covered under the Whistleblower Exception, says **Paul F. Schmeltzer**, JD, an attorney with Clark Hill in Los Angeles.

For example, if a whistleblower made an allegation that included PHI to the Equal Employment Opportunity Commission or a media outlet, their actions would not fall under the whistleblower exception.

"The most common scenario is a healthcare employee protected under the HIPAA whistleblower exception making allegations of fraudulent billing in the covered entity's medical practice," Schmeltzer says. "Healthcare employers would be wise to include information in their annual HIPAA trainings that discusses the limited nature of HIPAA's whistleblower exception and the consequences that could follow if the employee's disclosure does not meet the criteria of that rule." ■