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INSIDE

Relias Media
From Relias

JULY 2021 Vol. 40, No. 7; p. 49-56

Not All Revenue Cycle Employees Want a Job That Is Patient-Facing

Some registrars at Ochsner Medical Center in New Orleans clearly were not happy in their jobs. Patient access leaders decided to survey staff to find out why. "We wanted to better gauge the career path in which team members wanted to venture upon," says Ochsner Healthcare System Patient Access Manager **Monica James-Harper**.

All registrars completed an Aspiration Capability Engagement (ACE) survey with these questions: What are my career aspirations? What are my strengths? Where do I need to focus to grow? What motivates and energizes me?

Staff gave honest responses. One piece of feedback in particular stood out. "We learned that most individuals really don't like to be patient-facing," James-Harper says.

Many registrars admitted they really wanted to work behind the scenes. "For those staff, preservice or billing roles are a good fit," James-Harper observes.

Registrars were encouraged to "shadow" colleagues in those areas to learn about the department and vice versa. "It allows team members to network and get their names out there," James-Harper notes.

Sometimes, unhappy registrars find a better fit outside patient access. "In patient access, we only have a limited amount of positions to advance to," says **Brenda Sauer**, RN, MA, CHAM, FHAM, director of patient access at NewYork-Presbyterian/Weill Cornell Medical Center.

Recently, the revenue cycle department needed trainers during a system implementation. Some registrars had been great preceptors for new patient access hires but wanted fresh opportunities. "They liked teaching people and liked explaining things, so I encouraged them to apply," Sauer says. Four employees left patient access and moved into the trainer roles.

Other times, the problem is not the role itself, but the logistics. "Instead of losing a good employee who we invested in, we help them look for other opportunities," Sauer says. Some registrars could not work nights, weekends, or holidays any longer, and wanted regular hours. Sauer encouraged them to apply for jobs at a newly created physician billing office. This approach prevents employees from leaving the hospital altogether, and helps other departments fill open positions.

Recently, patient access created an "ambassador" role after opening a new hospital. Sauer put the word out: The department was looking for people with top-notch customer service skills. "Six ambassadors were hired from within the organization," Sauer reports.

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management **(ISSN 1079-0365) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Access Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672.

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Certain people have been perfect fits for patient access jobs, even though they have no relevant experience in the field. "When we are looking for new employees, we do look outside of healthcare," Sauer explains.

Many recent hires came from the hospitality industry. In particular, hotel workers are a great fit for jobs requiring good customer service. "A person who works at the front desk of a hotel in New York City has to be able to greet people, think quickly, and provide a next level of service," Sauer says.

At Rockledge, FL-based Health First, patient access staff can shadow other jobs. "If I have a registrar with a great work ethic who shows up on time every day, I don't want to lose that person just because they can't handle blood in the ER," says **Michelle Fox**, DBA, MHA, CHAM, director of revenue operations and patient access. Other registrars became bored working in outpatient registration where the same thing happens every day, but thrived in the unpredictable ED. Staff in preregistration might find they really hate talking on the phone all day and want a patient-facing role; others have a knack for the complexities of insurance and want to switch to the authorization team. Luckily, there is no shortage of roles in patient access. "We've had people go back and forth, from front end to back end," Fox says.

Registrars can shadow a shift for a morning or a full day. "Sometimes, they end up loving the job; other times, they realize it's not for them after all," Fox explains.

The perfect match is not always in patient access. One registrar brought a family member to the hospital and thought the radiology technician's job looked appealing. "We'll facilitate that as well," Fox adds. "We'll do whatever we can to find the right fit." ■

Put Entry-Level Patient Access Staff on Leadership Track

Years ago in patient access, "a growth plan was rarely discussed with frontline team members," says **Cassandra Gardner**, director of patient access services at North Colorado Medical Center in Greeley.

Patient access operates with a completely different mindset today. "We have a strong focus on encouraging and promoting emerging leaders from within," Gardner reports.

The annual employee engagement survey revealed a problem. Patient access staff were finding opportunities to advance within the health system, but outside of the department. "To keep our stars, we needed to evolve," Gardner admits.

Leaders looked at how other departments were improving retention, staff engagement, and morale. They created a career ladder based on those practices. The first version was specifically aimed at patient access representatives who had minimal experience with customer service.

"We added additional levels for staff to grow into, with more responsibility and experience required," Gardner recalls.

One example is a new "lead" role, with the formal title of "senior representative." The career ladder now covers senior representatives, associate managers, managers, senior managers, and directors. Gardner says several current leaders started out in entry-level jobs, and patient access is no longer seeing staff leave for other departments. "We are now seeing other departments

lose team members to join the patient access teams," she says.

At Phoenix-based Banner Health, many patient access employees have grown into leadership roles through the health system's Aspirations, Results, Challenge to Grow program. "Employees are given development goals, designed to push them out of their comfort zone," says **Jarrod Brown**, CHAM, senior director of patient access services.

Leaders check in regularly with participating employees to discuss progress. Recently, some employees were asked to be subject matter experts for a system implementation. "We checked with the project leader to solicit feedback on that individual's participation level," Brown says.

Patient access services also maintains an employee-led engagement team. "Employees are tasked with presenting various topics, such as an education item, progress on an action plan, or annual campaigns that Banner Health puts on," Brown says.

The objective is twofold. It helps staff become comfortable with public speaking. It also conveys important messages to staff from their peers. "Sometimes, messages can resonate better coming from an individual on the same level as the audience," Brown explains.

At Banner Thunderbird Medical Center in Glendale, AZ, some patient access staff are asked to attend an "emerging leadership" meeting. "In those meetings, we work on skills: How to set a smart goal, public speaking, putting together a PowerPoint presentation, effective communication, and conflict resolution, just to name a few," says **Chris Lugo**, CHAM, patient access services admitting director.

Later, the emerging leaders train new hires, take additional online training courses, and help existing leaders with process improvement projects. "The employees are also cross-trained into other patient access areas [the ED, admitting, OB, and the infusion center]," Lugo says.

Monica James-Harper, patient access manager at Ochsner Healthcare System in New Orleans, says the key to reducing turnover is simple: "Staff need to know there is room for growth within the patient access department."

The department promotes from within whenever possible. To do this, senior leads are given "stretch" assignments. One senior lead was asked to come up with a way to keep the department from creating duplicate accounts, and put a process in place to ensure two patient identifiers are used at every check-in. Another senior lead came up with the idea of making rounds in the lobby every 15 minutes to ensure every patient was checked in for their scheduled appointment.

The projects give the senior leads something to talk about when a leadership position does become available. "Many patient access team members have shared how impressed they are with the promotions that have taken place within the department," James-Harper reports. ■

EDITOR'S NOTE

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Some Departments See Safety Benefits in Biometrics; Others Press Pause

Biometric techniques, such as iris recognition, palm scanning, or fingerprinting, are used to identify patients at registration in many hospitals. "But it's important to note that it is not a 'one-and-done' approach," says **Julie A. Pursley**, MSHI, RHIA, CHDA, FAHIMA, director of health information thought leadership for the American Health Information Management Association.

To achieve and maintain a low duplicate record error rate, it takes "technology, people, and processes,"

Pursley says. "Without proper identification, matching patients to their unique health record will continue to result in patient misidentification."

Currently, the way registrars identify patients varies. The Patient ID Now coalition recommends a national strategy, emphasizing data integrity and quality and the use of technology.[1] "As more health data are shared via application programming interfaces [APIs], more patients will want the convenience and efficiencies of self-registering," Pursley predicts.

Biometrics, APIs, new registration systems, and interoperable electronic health records all are part of a national strategy for patient identification. As it stands now, patient misidentification is a recurring challenge, resulting in administrative inefficiencies, serious injuries, and even death," Pursley notes.

For several years, patients used hand scanners to check in at registration areas at Salt Lake City-based Huntsman Cancer Hospital. This was discontinued during the COVID-19 pandemic, but leaders expect to reinstate the program at some point, says **Junko I. Fowles**, CHAM, CRCP-I, supervisor of patient access and financial counseling. Although the department has no hard data to share, Fowles says, "discontinuing hand scanners may have contributed to registration errors, such as duplicate medical record numbers and incorrect patient selection."

Some patient access departments are reconsidering biometrics altogether. Winston-Salem, NC-based Novant Health was an early adopter of iris recognition in 2013. "We had huge success with it to start," says **Craig Pergrem**, senior director of preservice and onsite access.

In one notable case, registration staff even used iris recognition to identify an Alzheimer's patient who was found walking alone. But problems kept cropping up.

"It wasn't a good fit for us, and we de-installed in 2020," Pergrem reports.

Staff could never keep the system running properly. There were constant connection issues, necessitating cord changes, newer cameras, and software upgrades.

"It finally got to the point where we just unplugged, and we canceled the contract," Pergrem says.

Patient access went back to asking for driver's licenses or another form of government-issued identification. "Patients seem happier. There was a lot of 'Big Brother' mentality regarding it, and I know my team members are [happier]," Pergrem says. ■

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Same-Day Appointments Carry Value, But Auths Are Obstacle

Same-day appointments have become critical for hospitals trying to keep patients within their health system.

"In general, our patients want instant everything. It's just the society we live in now," says **Tracy Bird**, FACMPE, CPC, CPMA, CEMC, CPC-I, a Medical Group Management Association consultant.

For hospitals, the ability to offer same-day scheduling carries huge implications for patient satisfaction — and revenue. "Ability to access care is critically important," Bird notes.

If a patient cannot schedule an appointment for when he or she wants, that person probably is going to look elsewhere. They might turn to an urgent care center or ED that is outside the hospital system. From a revenue standpoint, this is terrible. "Many hospitals are still experiencing declining patient visits," Bird says.

Proactively working to put patients back in the pipeline using same-day or next-day appointments fills the revenue lost from all the surgeries that were canceled during the COVID-19 pandemic. "Patients want to be seen when it is convenient for them," Bird explains. Marketing same-day availability can draw patients who would not otherwise have chosen the facility or providers.

Certain facilities directed schedulers to work remotely when the pandemic started, an arrangement that continues in some places. However, this should not hinder same-day scheduling. "That's the beauty of remote scheduling. You can access the schedule from anywhere," Bird observes. It calls attention to the importance of creating systems that can handle real-time checking of eligibility and benefits. "That step is critically important. It just has to be done," Bird stresses.

Scheduling same-day appointments is only part of the solution. The hospital also has to be paid. "We need to know that patients have current coverage, whether they've met their deductible, or if the visit will be out of pocket," Bird says.

Sometimes, patients want a same-day appointment for a service that requires authorization. That is when things become tricky. "Those are a little bit harder to do," Bird acknowledges.

This is a particular problem for some high-volume services, such as pulmonary function tests. Some health plans require prior authorization for every test. If the hospital sees a lot of insured payers, it becomes a tremendous amount of work to obtain all the authorizations. "That's simply too onerous. At that point, you are having a conversation with the payer," Bird explains.

Revenue cycle leaders can clarify the tests are needed for every patient to set a baseline level. Some hospitals have negotiated to bypass the authorization requirement for those particular tests. "The argument, ideally, is backed up by clinical guidelines that show it's appropriate to perform the procedure on every patient," Bird says.

Also extremely helpful are data showing how often the procedure was approved. If it is approved 99% of the time, that is convincing proof the authorizations are a huge waste of everyone's time.

"That's the kind of data you should be able to get from your practice management system," Bird says. If the visit involves something that needs authorization, that is no reason to abandon same-day scheduling altogether. "There is always the option to at least get a patient in the door to be evaluated," Bird offers.

The provider can assess whether a particular test or procedure is appropriate. "For those tests that require authorization, it means a second trip back, and patients are not happy about that," Bird cautions.

That is one reason same-day scheduling, when handled by patients, "is a double-edged sword," Bird says.

Staff need to monitor those appointments closely, to verify insurance before the patient comes in. Some systems allow patients to upload their insurance card, making this easier. "The system should be able to automatically check eligibility and alert staff if something doesn't look right," Bird says.

Some payors do not give an answer for a week or 10 days, causing all kinds of problems. "That's when it's time to engage the payor in a conversation and say: 'You are putting an undue burden on our staff, and it's an access-to-care problem for your insured member,'" Bird says.

For hospitals that want to offer more same-day appointments, this is by far the biggest obstacle. "Most payors do not offer real-time authorization approvals," says **Dan Medve**, director of revenue cycle management at Cleveland Clinic.

Most health plans follow at least a 72-hour turnaround time for those requests. "This creates significant challenges to obtain an authorization prior to service for same-day appointments," Medve laments. This is especially problematic if diagnostic testing is needed "stat." The hospital often struggles to recoup reimbursement for these procedures because of a "no auth" in place. "Some payers do not allow retro authorization," Medve adds.

Cleveland Clinic has sidestepped some of these issues with a strong focus on preservice processes. In 2020, the department started offering patients video chats with financial advocates. "If there are financial clearance issues with the same-day appointment, this process allows the patient to get concerns addressed quickly," Medve explains.

Same-day appointments also were facilitated after the department negotiated some prior authorization exemptions. Health plans have agreed to this for certain procedures that often are approved preservice approvals or carry a high percentage of appealed approvals post-service, says **Robert McDaniel**, another director of revenue cycle management at Cleveland Clinic.

The department also uses technology to ensure payment for same-day appointments. "This includes real-time submission and decisions by automating the inbound/outbound transactions," McDaniel says. ■

Incorrect Orders, Missing Auths Hinder Same-Day Scheduling

Same-day scheduling is a priority at Maury Regional Medical Center in Columbia, TN, but there are two big obstacles:

• **Incorrect orders.** Physician offices must place an order (either by phone or fax) to schedule a procedure. Surprisingly often, a key piece of information is missing, according to Preservice Manager **Jennifer Smith**.

Orders need to include basic demographics: a diagnosis supporting the ordered test; evidence showing the test is medically necessary; the proper order of procedure per the radiologist protocol; and the physician's name, signature, and date of the order. If any of that is missing, the patient is put on the schedule regardless. "We work on the back end to get a correct order prior to the patient arriving," Smith says. Usually, staff are stuck leaving repeated voicemails to try to correct the problematic order. Even after multiple calls, it does not always work. "This results in a delay in the patient proceeding with their scheduled appointment," Smith notes.

Patient access has made some changes to avoid this situation. First, the radiology department created a booklet to

educate providers and prevent some common errors that hold up everything. "This helps providers order the appropriate test for the patient and the correct studies for with, or without, contrast," Smith says.

Someone might order a screening mammogram, but the patient really needs a diagnostic mammogram. It also is common for physicians to order a CT of the head with contrast, but the radiologist strongly suggests ordering it without contrast. "Nurses have confessed to being confused on what is IV contrast and what is oral contrast," Smith notes.

Patient access also met with physicians' office staff to review recurring mistakes that interfered with scheduling. "We also help the physicians' office navigate insurance websites to determine medical necessity," Smith says.

This was causing problems with health plans denying the ordered test, such as an MRI of the left lower extremity for a diagnosis of headache. "We do a lot of education on medical necessity," Smith shares. "The providers' offices do not find the payor sites user-friendly."

• **Missing authorizations.** "Every authorization request requires supporting clinicals to get the request approved," Smith says.

Usually, staff make multiple calls to the nursing staff to secure it, not always successfully. Many times, inability to make contact results in the need to reschedule the patient days later, pleasing no one. "Getting an approved precertification for the radiology test is dependent on if the prerequisites for the study were met and who the payor is," Smith adds.

Recently, some payors denied authorization for MRI of the spine unless patients already had undergone an X-ray or several weeks of physical therapy. "This makes it difficult to get patients added on the same day for certain radiology studies," Smith laments.

If patients cannot schedule the appointment at the hospital, most end up going to a freestanding radiology center instead. "We do everything within our power to get the patient scheduled same day," Smith reports.

The scheduling team also reminds the ordering provider's office to include the clinical notes with the order. It is important this happens at the time of scheduling to avoid hassles and hold-ups. "We promptly notify the physician office of any missing clinical notes that are needed to complete the request," Smith says.

If a patient really wants a same-day appointment, the scheduling and precertification teams work to make it happen. Schedulers contact the precertification team member who handles "stat" requests to find out if an authorization is required for that specific study. If not, the patient is put on the schedule immediately. If it does, the patient usually is scheduled anyway. "Simultaneously, the pre-cert rep will work on obtaining the authorization," Smith says. ■

'The Patient Experience' Includes Registration; Accurate Metrics Needed

Patient satisfaction surveys probably include at least a few questions about registration. The problem is patients really do not make a distinction between registration and the clinical service for which they have arrived. "Often, the terminology of the questions leads to answers about other areas," says **Heidi Kennedy**, director of patient access at North Mississippi Health Services in Tupelo. Previously, the patient satisfaction survey asked people to rate how satisfied they were with "wait time in registration." Of course, patients did not realize staff were asking them to consider only the time they spent waiting to register. They rated their satisfaction based on the overall time they spent waiting to be seen, including post-registration.

If a patient was registered immediately, but then waited an hour to be seen because a clinician was backed up, that person would probably rate satisfaction with "wait time in registration area" as low. To obtain better data, the patient access department reworded the question to "wait time to register." It turned out to be an important distinction. "What we have found is when wait time increases, patient satisfaction scores decrease, and vice versa," Kennedy reports.

Preregistration has greatly improved satisfaction because things go much smoother on the day of service. "Patients are better prepared. They know how much they owe, when applicable," Kennedy observes. "It decreases wait time and enhances the ease of registration."

Kennedy says two other specific metrics are helpful in telling the "patient experience" story. Respondents are asked to rate "helpfulness of the registration person" and "ease of the registration process." Patient experience with registration is notoriously hard to measure. "It gets so muddled across the scope of interactions that patients have," says **Debi Lasswell**, director of revenue cycle transformation at Bluetree Network.

Lasswell recommends creating a list of "quick hit" metrics to tell the story of how patients are treated. These could include scheduling lag time, appointment cycle time, cancelations or reschedules initiated by the hospital, patient estimate accuracy rate, the percentage of patient estimates provided,

and accounts sent to bad debt. "These are all good things to report out on, to monitor at a high level what's going on with the patient experience," Lasswell offers.

No patient comes to the hospital just to be registered, after all. They come for a test, procedure, or surgery. Therefore, when asked about wait times in registration, patients do not separate the chunk of time they spent waiting to be registered. They will look at the total time they spent in the registration waiting area.

"Regardless of whether the patient is waiting or being registered, it is all time that is keeping them from the service they actually came to receive," says **Sue Plank**, LCSW, CHAM, director of patient access at Goshen (IN) Health.

The department calls this time spent waiting the "patient experience time." There are three metrics the department uses to assess it: The actual number of patients who waited more than 10 minutes, the time it takes to register, and the percentage of accounts that are preregistered by the day before service.

Amanda Gordon, senior director for patient access and customer service at Portland, OR-based Legacy Health, says frequent use of the MyHealth patient portal is a good sign that patients are engaged. More than half of payments are now made through this portal. "There's a lot more automation than we've had in the past," Gordon reports.

Before, patients had to call customer service to set up a payment plan. Now, patients can set that up online, including adding new balances to existing payment plans. Other sources of patient experience data come from community members who offer feedback. "Sometimes, the trap you fall into is that you know the business so well, but it doesn't necessarily make sense to the patient," Gordon shares.

Assumptions are challenged based on what the community members report. One incorrect perception was that older patients were not inclined to want to use automation. "This is something that was not supported by community members' input," Gordon says. Based on the feedback, the department is making a strong effort to engage patients before service whenever possible. "We start to have the conversation about the procedure they're going to have. We provide estimates," Gordon says.

Patient access staff are expected to fully understand the revenue cycle. "In the past, we gathered a few pieces of demographic information, and sent the patient on their way," Gordon recalls.

Today, patients expect staff to help with complex questions about financial assistance, price estimates, and enrolling in Medicaid. Secret shoppers are another method used to keep an eye on patient interactions. "It's not punitive; it's purely to educate," Gordon says.

Observers look for whether staff explain why the patient might receive an additional bill from an outside party. "Otherwise, patients may feel they are getting fraudulently billed," Gordon explains. All these efforts work in tandem to send an important message to patients — the hospital wants to continue to be their provider. "All of these things that we do are really helpful to build a relationship," Gordon adds. ■

Denial Prevention Tactics Are Front End-Focused

Revenue cycle departments spend lots of time and money appealing denied claims. However, some hospitals are diverting resources to the front end instead. "Getting it right up front makes so much more sense than staffing the back end for extensive clean-up," says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle operations at Emory Healthcare in Atlanta.

Kraus gives these examples of insurance-related errors that registrars can correct before claims are sent: incorrect, missing, or unverified insurance; incorrect coordination of benefits; missing orders; scheduled services that do not match the services rendered; missing authorizations; unverified coverage for the date of service; failure to notify the carrier of the patient's status (inpatient or observation); and missing Advance Beneficiary Notice of Noncoverage.

"It's a mystery to me why every hospital doesn't invest in robust financial clearance, with well-defined rules of what constitutes a complete pre-admission from the insurance perspective," Kraus offers.

Financial clearance simply might not be possible, as with some ED visits or same-day appointments. Patient access needs to know when it is OK to defer a procedure in those cases because of incomplete or pending information. "Rules regarding deferred procedures are determined by hospital administration," Kraus explains. "Some facilities are stricter than others." In the absence of well-documented guidance, patient access risks "getting caught in the middle, regardless of what they do," Kraus adds.

When denials are analyzed for financial clearance shortcomings, the group of denials that were caused by approved exceptions from policy can be put in a separate bucket.

"You can determine how much the deviations cost the facility, and whether the exceptions should be revisited," Kraus offers.

Possibly, the hospital allows certain physicians to admit more than the expected share of financially challenged patients because those physicians bring

the hospital a lot of business. "But if they bring in too many indigent patients racking up huge, uncollectible bills, the practice might warrant review," Kraus cautions.

Preventing denials on the front end is a major focus at Philadelphia-based Thomas Jefferson University Hospitals and Jefferson Health. The sheer volume of denials demanded this shift. "You can't just do a backward look on what your write-offs were. You have to be proactive and look at the denial inflow so you can properly assess the collectability of your A/R," says **Cynthia Fry**, PhD, senior vice president of revenue.

The department is using artificial intelligence (AI) to combat some front-end denials: failure to timely notify the payer of an admission and "no authorization" for radiology, cardiology, and surgical procedures. First, the AI determines if an authorization is required. If so, the account is routed to a patient access employee who submits the request. "Our AI continually checks the payer portals to retrieve the authorization," Fry says. "It works like bookends on the authorization process."

Sometimes, claims are not flat-out denied. Instead, the health plan downgrades the claim, which means less revenue for the hospital. "We refer [downgrades] to case management to review," Fry says.

If a "downgrade" denial happens, case management determines if they will appeal it. Assuming the patient met admission criteria, case managers send the clinical documentation. If case managers agree with the payor's decision to downgrade the claim, the account is returned to the revenue cycle. "The claim is rebilled as observation. The inpatient balance is written off," Fry says.

For cases in which the patient did not meet inpatient criteria, staff conduct a root cause analysis. It is possible the admission occurred when case managers were not present, or the patient really should have been placed in observation.

"It's a team sport," Fry notes. "Patient access, physicians, care managers, and revenue cycle need to partner to be successful."

At Phoenix-based Banner Health, simple mistakes, such as bad addresses or incorrect ID or group numbers, were causing many denials. "We all know that a missing prefix from a policy number or a miskey of one digit for any of the policy information can cause a claim to hold up with the payor for incorrect data," says **Amber Hermosillo**, revenue cycle educator and quality director.

The department found success with an insurance verification tool. "The integration to our host system allows a real-time quality check as the registration is taking place," Hermosillo explains.

Any registration quality issues are identified quickly. Patient access updates insurance information as needed. "This reduces A/R days. It provides our patients with a better billing experience from the point of service," Hermosillo reports.

The preservice department recently transitioned to a centralized team. "This team is able to clear a high number of patients prior to their services while maintaining exceptional registration quality scores," Hermosillo says. ■

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