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# Is an MSP form required with no patient present?

*Debate rages, interpretations differ*

The latest topic to have access managers frantically e-mailing their contemporaries across the country is a familiar refrain with a new verse or two. It's a question of handling the Medicare secondary payer (MSP) form, and it seems the answers are as varied as the states and regions from which they come.

The newest twist regarding the MSP questionnaire, designed to determine whether a source other than Medicare should be the primary payer, is the requirement that providers complete the form even when no patient is present.

"It's the hottest thing right now," explains **Betty McCulley,** CHAM, corporate director for admitting and the centralized business office at Baptist Health System in Birmingham, AL. "The Health Care Financing Administration [HCFA] got strict around last October about filling it out on specimens. Even though we don't have the patient present — just a specimen from the patient that is being tested for pneumonia or some other condition — we have to hunt up that patient and ask the MSP questions."

If the patient is in a nursing home, for example, and perhaps unable to answer the questions, that means convincing someone in the facility to provide the name of a relative, she says. Once that individual is contacted, he or she may or may not know the answers, McCulley adds.

"It is so labor-intensive, and nobody has the staff to do that kind of calling and hunting," she says. "It's not like people understand what we're asking, so the integrity of the information is questionable, in my opinion."

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Another complication, McCulley says, is that HCFA apparently is requiring this step of hospitals but is not monitoring reference laboratories for compliance. "That hurts us competition-wise, so we are getting shot at from every direction."

"What concerns us," adds **Pete Kraus**, CHAM, a business analyst with patient accounts services at Atlanta's Emory University Hospital, "is that a stand-alone lab that's not part of a hospital doesn't have to do this. That can take business away from hospital labs because their clientele don't want their patients bothered [with filling out the form]."

The confusion doesn't stop there. Baptist Health System has been told by the Medicare intermediary in Alabama that it is required to have the MSP questionnaire completed in such cases, and Emory received similar feedback from its intermediary, say McCulley and Kraus. However, intermediaries in other states have interpreted the requirement differently.

Veritus Medicare Services, the Medicare Part A intermediary for the majority of providers in Pennsylvania, has said that an MSP form is not needed if a hospital does a test on a specimen received from a doctor's office or on one obtained by hospital personnel at a nursing home or during a home health visit, says **Ellen M. Byrne,** CHAM, RN, MS, manager of patient access at Community Medical Center in Scranton, PA. **(See related story, p. 75.)**

A Medicare customer service representative presented an inservice Feb. 16, 2000, for Harris Methodist Fort Worth (TX), reports **Linda Powell**, director of patient access. It included the following information:

1. End-stage renal disease date will always be required when completing the MSP questionnaire.
2. Always attempt to capture the correct date (for retirement, death of spouse, etc.).
3. Month and year are sufficient for dates.
4. In the case of a hospital receiving a specimen, Medicare does not require an MSP questionnaire (for nonpatients).
5. An MSP questionnaire is required every 30 days on recurring patients.

Louisiana has two Medicare intermediaries, notes **Beth Ingram**, CHAM, director of patient business services at Touro Infirmary in New Orleans, and each has a different take on the subject. "Mutual of Omaha says it is required but not enforced, and Trispan says it is not required. No one can provide regulations that clarify."

Ingram says her facility hired compliance attorneys whose opinion is that the law does not

exclude specimens. "If anyone has the regulation showing them as exclusions, I would really appreciate [seeing it]."

Whether the MSP form should be filled out with no patient present "is a very tough issue for everyone," she adds. "It is a very problematic situation that again is compounded by the vagary of the law. I believe HCFA knows it is ridiculous to expect that you can get this information when you do not even see the patient, but [HCFA] fears the reaction of the Legislature if it comes right out and says that.

"We always have to remember why they instituted this form to begin with," Ingram says, "and that is to protect our tax dollars from being used for services that truly should be paid by a third party. They were trying to protect Medicare dollars from being misspent. If HCFA comes right out and says, 'OK, we are going to exempt specimens because it is too hard to do,' they are in essence ignoring the potential of paying for services that should have been covered by someone else."

### *HCFA rejects new approach*

Emory's attempt to make the MSP questionnaire more user-friendly received a thumbs-down from HCFA auditors, Kraus says. "We tried to combine the series of 23 questions to make them easier to answer while still getting the right answers," he notes. "Although I'm convinced we were making accurate coordination of benefits [COB] assessments, the auditors did not like it one bit. They wanted us to include every question individually."

Because Emory wasn't able to change the online system for asking the MSP questions right away, registrars presented them to patients from printouts for a few months, Kraus says. "The question-and-answer requirements were daunting in manual mode, even with the availability of system prompts on the printed text. It's hard to recommend the manual approach as a permanent solution. MSP questionnaire compliance is a serious enough issue to warrant a look at stand-alone systems, if the main admission / discharge / transfer [ADT] system can't cope."

On the other hand, he adds, a competent ADT system can improve the quality of the MSP questionnaire. "Ours prompts the user to answer questions in correct sequence, based on the answers given to previous questions. Certain data, such as retirement dates, are pulled from elsewhere in the system when the questionnaire

## Here's one response from an intermediary

*'No MSP form required'*

The Hospital and Health System Association of Pennsylvania in Harrisburg issued memos to its members dated April 2, 1999, and Sept. 3, 1999, that included several questions posed to Veritus Medical Services, the Medicare Part A intermediary for most providers in Pennsylvania.

Here are those questions, with responses from Veritus:

• **Can a hospital either change, modify, or eliminate any of the questions listed on the MSP form?**

A hospital cannot change, modify, or eliminate any of the questions on the MSP form. Hospitals may add questions, but they should be listed at the end of the "mandated" questions.

• **Is an MSP form required when a hospital performs an outpatient diagnostic test using a specimen obtained from a Medicare patient not physically present?**

If a hospital performs an outpatient test on a specimen received from a beneficiary not physically present, no MSP form is required. Hospitals must, however, have procedures in place to attempt to identify other insurance coverage by checking the common worker file, the intermediary files, or the hospital's own files for previously received insurance information.

• **Does an MSP form have to be completed if the patient is not present at the hospital?**

No. If the hospital does a test on a specimen received from a doctor's office, an MSP form is not needed.

• **What if the specimen is obtained by hospital personnel at a nursing home or during a home health visit?**

Because the patient was not at the hospital, no MSP form must be completed. Hospitals still should check their internal computer files for possible insurance information they may have obtained from a previous visit. ■

indicates a patient or spouse is retired. The system determines COB based on which questions are answered and tells the user what it is."

Kraus points out, however, that such help does not excuse the registrar from knowing what is being asked. "Patients don't always provide straight answers," he says. "Access staff must sense when they're being bamboozled by ignorant or devious patients. Staff must be especially conscientious in completing all their registration screens, since data in certain fields may work interdependently with the MSP questionnaire."

Another issue, Kraus says, is that systems can be defeated or bypassed if you know their weaknesses. "Until recently, our system had some defects and was failing to automatically generate certain codes we were expecting," he adds. "That got us into trouble during a MSP questionnaire audit. That's why serious Q&A is essential with MSP questionnaires."

The system was updated in April, Kraus notes, and now takes care of all MSP questionnaire-related codes.

### Grass-roots action planned

Members of the Washington, DC-based National Association for Healthcare Access Management (NAHAM) are rallying around the MSP issue, McCulley says, and that organization does have a track record in the area of grass-roots activism.

"A number of years back, [hospital access personnel] were required to have every Medicare patient sign a form saying they were aware of their rights," she says. In every state, the interpretation by Medicare intermediaries was that the hospital had to retain a copy of the forms, McCulley notes. After NAHAM members protested the requirement, which generally was decried as a paperwork and filing nightmare, it eventually was eliminated. "An Important Message From Medicare" still must be distributed to patients, but a signed copy no longer must be kept on file. In fact, she adds, "HCFA claimed it never required that."

McCulley says she and her NAHAM colleagues plan a similar campaign regarding the MSP requirement. Having to fill out the MSP questionnaire for lab specimens is particularly frustrating because when the paperwork for a test is given to the hospital, it includes information on other insurance coverage, she adds. "We verify Medicare coverage on-line here anyway, so it's almost ludicrous to have to do it." ■

# 'Learn as you go' is motto as APCs join health care

*It's still unclear what role access will play*

Now that the dust is settling on the final rule for the outpatient prospective payment system, hospitals are getting down to the business of determining what the advent of ambulatory payment classifications (APCs) means to them.

The role access services will play varies, depending on whom you talk to, and there is a big "learn as you go" factor, most sources say.

Despite the Health Care Financing Administration's (HCFA) prediction that hospitals will see an overall 4.6% increase in reimbursement the first year of the new system, most industry observers say significant *decreases* in reimbursement will be more common.

A study of some 60 member hospitals of the VHA West Coast projects that the majority of those hospitals will see double-digit decreases, says **Karen Oppliger**, CHE, director of managed care for the El Segundo, CA-based organization. "Initially, before the final regulations, HCFA said there would be a 5% to 7% decrease in reimbursement, while we found a 16.3% decrease. When we reran the numbers, we found an average decrease of 17%. I don't think it will be that bad, but it certainly won't be plus 4.6%."

> "We have to identify the technology to monitor what we expect to get paid and what we actually get paid."
> Karen Oppliger, VHA West Coast

In any event, Oppliger says, two issues are key to getting a handle on APCs. "First, everyone needs to identify the grouper. The challenge is where you're going to house that." She recommends putting the grouper, which is software that looks at all the care, tests, and services given to a patient and determines whether all the necessary codes have been used, on the front end and back end of the billing process to fully understand the process.

"Another thing is that we have to identify the technology to monitor what we expect to get paid and what we actually get paid," Oppliger adds.

"That will be very valuable, especially in the first six months."

The most important thing for access managers to understand, whatever their level of involvement in coding, she says, is the increased emphasis on accuracy. "What we've been talking to people about is [communicating to] key stakeholders — and they are in various parts of the organization — that now, more than ever, whatever you do to the patient needs to be captured in the chart so that individual services and devices will be captured in the billing."

Before, she points out, outpatient billing wasn't driven by coding. "It wasn't that specific. Now, what you code and also how you document it influences what you are paid."

## CCI complications

Access managers will be affected in a host of ways, Oppliger says, and should, first of all, be included in any APC task force formed by an organization. "One of the things that is more critical now is the coordination of getting the patient through the system — the encounter process, the visit process — because who bills for what is so important," she adds. "One of the questions to ask, for example, is, 'Do you need a health information management person in the emergency department?'"

The issue of late charges is critical, Oppliger says. "You can go through and rebill, but you need to get everything on the chart and posted quickly. You need to review the process to make sure that when the bill is sent, it's complete and accurate. The bar's a little higher now."

Training programs are important because the accuracy of coding is so crucial, she notes. "I've heard [health care managers] say historically that those doing the coding in the outpatient areas are neophytes. That is no longer true. Illogically, this reimbursement methodology, which will probably result in less reimbursement, will demand more FTEs [full-time equivalents], but [hospitals] aren't likely to get them.

"Focusing on coders and getting them to work more efficiently is an interesting challenge we've faced before [with the advent of the inpatient diagnosis-related group (DRG) system]," she says. "You staff up to get less money."

APCs drag along a set of rules called the Correct Coding Initiative (CCI) that looks at the relationships between groups of CPT codes, points out **Jack Duffy,** CHAM, corporate director of patient financial services for ScrippsHealth in San Diego. "If you do one procedure, which will subsequently group into an APC, you may not bill other procedures with it," Duffy notes. "In radiology alone, there are 8,000 conflicted procedures."

That means an order that has to be filtered through medical necessity guidelines now must be filtered a second time through a piece of software that checks for CCI conflicts, he says.

"In radiology, 30% of the orders can be modified from the time the patient presents or schedules to the time when the radiologist makes adjustments," he explains. "In the past, it's been 'the good ole boys club.' The orders didn't have to match the work to be done. They would joke that 'Dr. Jones never gets it right, doesn't know his left from right, and we always have to fix [the order].'"

Now, he says, "fixing" is illegal, which leads to the question of what role access will play in the process. "These things require precoding of all services, and CCI requires all correct CPT codes, so you have to go through the process of whether [the codes] are conflicted and only bill for those that aren't.

"I think the software of the future will say, 'Don't send that claim because you can't bill Medicare for these two services,'" Duffy adds. "So I'm saying conflicts should be understood from the point of contact so you don't have to rebill."

## How it works

There are a number of ways to get the specificity required for accurate coding under the APC system, notes **Pete Kraus,** CHAM, a business analyst in patient accounts services at Atlanta's Emory University Hospital. It can come through the access department if the information received from a physician's office or taken from central scheduling was complete and accurate, he says.

"You might get it from access if the information received from the doctor said, to use a completely hypothetical example, not just that the patient was having a hangnail removed, but that it was being removed from the left index finger," Kraus adds.

Even that level of detail may not be all that's necessary, he says. "When the patient presents for treatment, other tests might be run or unforeseen procedures performed. Also, HCPCS/CPT4 codes appear on charges that access is not likely to see. Maybe the ancillary department can

include [the necessary information], or maybe it can only be done by looking at the procedural notes that go to medical records. If that's the case, medical records personnel could add the codes.

"If, while having the hangnail done, the patient is also having something done to the right knee," he points out, "you now have two procedures. Unlike with DRGs, where there is always just one code, you can have multiple codes. You won't get paid the whole amount [for both procedures]. The second one is prorated."

If, because of inaccurate coding, the bill doesn't specify that it's the left index finger, "that could change what you're going to get," Kraus says. "That may mean no payment for the hangnail, just the payment for the knee. Bottom line, access is not likely to have complete information for APC coding."

## Ensure coding is accurate

Hospitals don't *have* to use a grouper to determine the correct APCs in advance, he points out. "When it reaches Medicare, it will be done, but if [hospitals] don't do it, they won't know whether they're putting in the charge modifiers they need or if they have conflicted procedure codes."

As to what point in the process a grouper is used, Kraus says he may have created a small stir when he mentioned Emory's current strategy at a recent conference of users of Atlanta-based McKesson HBOC software. While that vendor and others have come up with all sorts of software to use on the billing end of patient accounts, he notes, his organization doesn't plan to go in that direction.

"Instead, we're working from the medical records perspective," Kraus says. "The APC grouper will be installed on our medical records system, and there will be software to monitor and edit for CCI. In the final analysis, we think medical records has the best repository of data and has the greatest expertise to ensure that coding accurately reflects the tests, procedures, and treatments our patients receive."

There are several keys to making such a system work, he says. "In order for medical records to have complete information, there must be excellent data flow from physicians and ancillary departments. The medical records APC grouper and CCI software must also be able to factor in codes that appear on charges. I don't think that is part of the normal medical records/billing flow for most facilities. That's something we're working on here at Emory."

Because medical records was not coding outpatient accounts before, that department may not even get a record of what procedure is being done, and if it does receive one, it may not be complete, Kraus explains. "There will be a big need for education of ancillary departments and for getting that flow of information."

At Emory, medical records already codes some outpatient records, just not all of them, he says. "We hold bills for the outpatient claims that medical records codes until coding is complete. That said, medical records' volume is likely to increase with APCs, and the factors that contribute to accurate coding are much more complex."

One reason for the emphasis on installing a grouper on the billing end, he suggests, is that vendors believe their customers want to estimate APC coordination of benefits (COB) amounts at the time of billing. "We're not going to try," Kraus notes. "Medicare outpatient claims reflect only 5% of our business in terms of dollars, and not all claims will be paid under APCs. It doesn't seem worth the effort."

Of course, Emory wants to be paid correctly, he says. Monitoring payments will feed charge and medical records data to its costs accounting and claims adjudication system, as it already does, and will let that system calculate the APC amount to compare with what Medicare actually pays.

Kraus points out that APCs are used to calculate only Medicare reimbursement, at least for now. "So why code all outpatient accounts to APC standards? One reason is that when research studies are conducted in years to come, it is important that all accounts are coded the same way. Otherwise, the data is at best misleading, at worst useless."

## Access role questioned

Although noting that hospitals with centralized scheduling systems would have more of an interest in handling APCs at the point of access, Kraus says he sees little point in doing so otherwise. "I suppose the point would be that the level of coding required to deal with APCs cannot be handled effectively by access staff," he adds. "At best, they can be a pass-through. I suppose you could add professional coders to the staff, but why do that when coders are a scarce commodity and medical records has the expertise? We'll see how it all plays out."

Kraus emphasizes that his and other health care facilities are now "in the interpretive stage" with APCs. "Perspectives change daily, and what we plan to do now will almost certainly require revision as we get further into the process."

Whatever approach a hospital takes, he suggests, it should make every effort to follow HCFA rules and to obtain clarification from HCFA or its fiscal intermediary when unsure how to proceed. "There are tons of APC-related Web sites. Try the HCFA [www.hcfa.gov] and the Healthcare Financial Management Association [www.HFMA.org] sites for starters." ■

# Inpatient-only list, copays are hot topics of PPS regs

*Some industry analysts are pleased*

The inpatient-only procedures list and the limit in beneficiary copayments are two primary topics of debate regarding the final outpatient prospective payment system (PPS) regulation.

In the proposed regulations, the Health Care Financing Administration (HCFA) had a list of 1998 procedures that would be paid only if they were performed on an inpatient basis. Those procedures were chosen because of their invasive nature, the need for postoperative care, or the underlying physical condition of the patient requiring the surgery.

In the final rule, 195 of those procedures were moved into the outpatient category, where they would be covered under ambulatory payment classifications (APCs). The procedures that were moved to the outpatient setting include laparoscopic cholecystectomy, partial mastectomy, and coronary and noncoronary angioplasties.

Hospitals will need to be aware of which APCs will be paid on an outpatient basis and which will be paid on an inpatient basis, says **Darice Grzybowski**, RHIA, national manager of HIM industry relations with 3M HIS in Salt Lake City. "Certain patients, based on medical necessity, better meet inpatient criteria, and some may better meet outpatient criteria. Insurance companies and HCFA may have different guidelines on what status patients should be in to meet insurance payment criteria, but this is different than medical necessity criteria.

"The bottom line is that the physician's order and hospital criteria for admission must indicate what status a patient is directed to, and payment is based on that documentation in the medical record," she adds.

Other industry analysts were pleased that HCFA took some of the procedures off the inpatient-only list. "Technology and the settings regarding how things are done are changing all the time and certainly at a much faster rate than HCFA's policies could ever keep pace," says **Sue Prophet**, RHIA, CCS, director for coding policy and compliance at the American Health Information Management Association in Chicago. "My concern is that the inpatient-only list might actually hold back some of those technological changes."

For example, a technique for doing a particular procedure may be developed that could be done on an outpatient basis. If hospitals were only going to get paid if they performed the procedure on an inpatient basis, they would continue admitting those patients, Prophet says.

"A medical review of medical necessity on an after-the-fact audit basis would be a better method of making sure that hospitals were performing procedures in the setting that is the safest and most appropriate for that type of procedure rather than just making a blanket statement that this procedure has to be done on an inpatient basis until we say otherwise," she says. "I think more of that should be left to the clinical judgments of the providers."

HCFA's decision to move some of the procedures back to the outpatient list was a response to some of those concerns, Grzybowski says. "I feel HCFA listened to the comments about that and responded appropriately."

### *Software can save the day*

Now that the final regulations have listed the procedures that must be done on an inpatient-only basis, hospitals need to get their software in place, Grzybowski says, "You need to make sure you have a list available or software that screens patients at registration that says, 'This procedure is inpatient only.'"

HCFA also has used the final rule to limit what Medicare beneficiaries pay in copayments. "HCFA has recognized that Medicare patients have been paying an inappropriate share of co-insurance or copayment to the hospitals," Grzybowski says. Current rules stipulate that Medicare beneficiaries pay 20% of billed charges.

When HCFA pays a reduced rate to insurance companies, though, the remaining balance isn't based on the reduced rate but is prorated from the initial charges. That means beneficiaries could spend 50% or more on copayments for certain procedures. HCFA, therefore, decided to set a cap or a limit as to what beneficiaries would pay for a copayment so they would not end up paying the disproportionate amount.

The final rule includes a provision designed to transition the copayment eventually to the desired 20%. Hospitals have the option of discounting the total price of the copayment before HCFA does and using that discount as a marketing tool to attract more patients. With reimbursement being reduced in so many areas, however, Grzybowski doesn't expect many hospitals to offer the discount. Nor does she expect that patients would switch hospitals just for that reason. "Patients are loyal to their doctors," she says.

As with the inpatient-only procedure list, hospitals need to ensure their software can handle the new calculations of the copayments, she says. "That's something hospitals are going to have to get used to [evaluating]." ■

ACCESS FEEDBACK

# Access managers share preregistration practice

In the June *Hospital Access Management*, **Liz Kehrer**, CHAM, manager of patient access at Centegra Health System in McHenry, IL, sought feedback from her peers at other health care facilities on their preregistration practices, with the goal of improving Centegra's performance in that area.

Kehrer heard from **Marne Bonomo,** PhD, RN, director of patient access at Clarion Health in Indianapolis, who was seeking similar information on behalf of the University HealthSystem Consortium, to which her hospital belongs. Kehrer and Bonomo describe their own operations and pass along some responses they received from these access managers:

- **M. Holly Hiryak**, director, hospital admissions, University of Arkansas for Medical Sciences Medical Center, Little Rock;
- **Mark A. Underberger**, financial arrangements manager, admissions, Shands at the University of Florida, Gainesville;
- **Diane Shebelski**, manager, patient registration, central scheduling, Wausau (WI) Hospital;
- **Marjorie Sisson**, director of transition management, University Medical Center, Tucson, AZ.

**Liz Kehrer**

We just succeeded in creating a career path in patient access. We've been experiencing turnover and recruitment difficulties due to the low unemployment in the county and competition with customer service positions that do not include weekend work. We have a new patient access trainer who is responsible for quality assurance and training for the system. I'm also trying to get approval for a coordinator/supervisor at each hospital. It has been so difficult trying to balance two campuses' operations, plan for the future, recruit, counsel, etc.

### *Centegra's staffing levels*

We have admission counselor 1, which is the entry-level position. The next step is admission counselor 2, which includes the more sophisticated registrations and easy financial information (payment plan options).

Then we have admission counselor 3, which covers preregistration. These are the most sophisticated registrars, whose role includes calculating patient share, financial counseling, payment arrangements/collections, and advance beneficiary notice screening.

The financial counselors and insurance verifiers report to me. The financial counselor is in the main hospital to provide bedside counseling for patients who were not preregistered. The insurance verifier is part of the preregistration team. We will be starting to collect copayments, deposits, deductibles, and co-insurance. I'm seeking advice from someone who may be further ahead in the process who can share what worked well and what didn't and how we can make our transition smoother and not alienate or upset our customers in the process.

What I envision for the preregistration team is this:

1. The preregistrar will register scheduled patients, including obtaining insurance information.

2. The preregistrar hands off to the insurance verifier, who reviews and obtains benefits, calculates patient share, and forwards the information to the originating preregistrar. Accounts with verified benefits would not require a copy of the insurance card on the day of service.

3. The originating preregistrar calls the patient for financial counseling and payment collection (credit card via phone) or arrangement.

4. The account is documented for the patient's arrival. The preregistration team will be off campus in another building.

I have requested in the capital budget:

- a forms writer to allow remote form printing;
- an on-line insurance eligibility system to provide expanded benefits information, which will improve financial counseling;
- a radio frequency upgrade in the emergency department for connection to the main computer system;
- portable personal computers to allow emergency department bedside registration in the system.

The on-line insurance eligibility system executes a benefit search during the registration process to expedite the process without increasing full-time equivalents (FTEs). ▼

**Marne Bonomo**

We are centralizing preregistration for our three hospitals and moving all necessary expertise to the front of the registration process. We would like to preregister as much as possible and make registration a formality for obtaining signatures and copies of insurance cards, wherever possible.

We want our registrars to have the ability to provide insurance benefit verification. Financial counselors will move up front except for a small complement of people who actually set up payment plans for self-pay patients and enroll eligible patients into government plans.

We are centralizing our training program, working on a patient access career ladder. We hope to stimulate organizational change in pay practices and reward and recognition to improve retention of the best and brightest.

We also have tightened our requirements for employee applicants. What are your requirements? We are in Indianapolis and are having a staffing crisis along with all of our competitors. Turnover is high and applicants are scarce. Our competitors have actually disbanded their training unit and placed all support staff in registration positions to fill vacancies.

Does anyone have centralized preadmission and / or upfront insurance verification? Where do your financial counselors report? What are their responsibilities?

If you have recently implemented changes or improvements in your registration / preregistration / insurance verification, what did you do, and why? Do you collect copayments upfront? ▼

**M. Holly Hiryak**

We preregister about 400 to 500 patients a month. I have 1.8 FTEs totally dedicated to the process. We do not have any type of on-line insurance verification, but we do call for benefits or check the Omnipath prior to making the preregistration call. Patients are informed of any deductibles, copays, etc., and are expected to pay when they present for admission / surgery. Our facility never collected upfront prior to this, so we continue to educate patients to the process.

One preregistrar works 7:30 a.m. to 4 p.m., and the other one works 11 a.m. to 8:30 p.m. The early person contacts primarily the Medicare population, while the other one concentrates on all others. We discontinue calls at 8 p.m. because we get complaints if we call after that time.

We are beginning to see staffing / recruitment problems, and we have tightened our entry-level requirements — basics like keyboarding. We still have centralized training but are struggling with the content and qualifications of trainers. I have submitted the beginnings of a three-level job description to our human resources department in an attempt to begin developing a career ladder. I would like to someday develop an "access specialist" training curriculum, but I never seem to have the time.

I envision including, of course, the basics of registration and coding, extensive insurance and managed care training, financial counseling, and dealing with the public in general.

Through process redesign a few years ago, all of our frontline staff were cross-trained to perform all functions. I have no problem with this concept. I just don't think we have adequately prepared staff. I would be interested in any of your findings.

Additionally, if you are interested in developing some kind of "access specialist" curriculum that could be marketed nationally, let me know. Other specialists, such as coders, do this with some degree of success. ▼

**Mark A. Underberger**

Shands currently has separate registration at all hospitals. There may be some value in centralizing when we are all on the same computer system. At the University of Florida campus, all registration is centralized under the admissions department. There are three major areas: inpatient / surgery, emergency department, and outpatient services.

All staff have a set of financial counselor responsibilities. We do not have just self-pay people. Insurance verification and precertification are done whenever possible, and copayments are collected or otherwise arranged for in all areas. We currently collect about $3 million a year from patients at point of service. ▼

**Diane Shebelski**

Registration is centralized in our hospital, and we have three areas within the registration department — registration, preregistration, and insurance verification. We preregister 95% of all scheduled patients, who are scheduled through our central scheduling department. Patients present to their point of service the day of the test or procedure, and staff in those reception areas take the account from a pre-status to a billing status and have the patient sign the agreement for service.

The insurance verification area verifies all day surgeries, magnetic resonance imagings, heart catheterizations, angiograms, cardioversions, myelograms, sleep studies, and IPs. Registration does not collect a copayment. It does, however, take copies of cards when possible. We are developing an insurance card file for each area to reference, which is especially helpful when preregistering by phone.

We also have a strict performance audit report, which is distributed monthly to all staff. Indicators are as follows: Medicare secondary payer completion, scheduled patients vs. preregistered, registration accuracy, patient satisfaction survey, and insurance verification accuracy.

All staff are cross-trained in each area and are expected to rotate on a month-by-month basis. Patients welcome our process because they don't need to stop in registration the day of their test or procedure. ▼

**Marjorie Sisson**

We're working on an on-line eligibility verification system. The requirement is 100% eligibility and verification. Our registration staff are centrally managed and located in various areas of our institution, such as admitting, the emergency department, outpatient, and physicians' offices.

We have a central training program with one full-time trainer and a trainer / registrar in the emergency department and are working toward an admissions coordinator / trainer. We lost one trainer in a cost-reduction effort. We're developing a ladder on which staff are classified as I, II, or III. You cannot become a II unless you've worked as a I for one year and demonstrate the skill competency and values at a specific level. Our minimum hiring requirements are three years billing or registration experience.

Our staff are completely responsible for all unbilled accounts receivable. Once we're done, coding / charge entry takes place at the point of service, and the claim drops. In some cases, we're coding the charges. We have become very aggressive in collecting copayments upfront. We also are developing systems for handling ambulatory payment classifications and a pre-service module for advance beneficiary notice. We are working on enhancing the Medicare secondary payer questionnaire to make it more user-friendly for patients and staff.

*[If you would like to provide feedback on this issue, Kehrer can be reached at Centegra Health System, 4209 Medical Center Drive, McHenry, IL 60050. Telephone: (815) 759-4061. E-mail:lkehrer@centegra.com. Bonomo can be reached at mbonomo@clarian.com. Hiryak can be reached at HiryakHollyM@exchange.uams.edu.*

*If you would like feedback from your peers on any access issue, please contact editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com.]* ■

# Ease of access is focus of ScrippsHealth project

*'CRM' is latest buzzword*

It's the latest thing, but it's not really new. Customer relationship management (CRM) has been the health care buzzword for the past six to 12 months, says **Nancy Harkin**, senior consultant with Southfield, MI-based Superior Consultants. It's always been true, she points out, that organizations putting the customer first generally flourish.

With that in mind, Harkin says, a team from Superior is assessing the ease of access for customers at ScrippsHealth in San Diego and looking at the potential for consolidating isolated pockets of activity into something called a customer fulfillment center.

"We will be looking at, based on this assessment, what kind of technology will work best to automate various portions of work flow for the biggest return on investment," she says. At the same time, Harkin adds, the goal will be to create the easiest access possible for physicians and employees, as well as for patients and prospective patients.

## *Center may offer on-line registration*

The end product, she says, will be a hybrid of CRM and contact center — or call center, as it is sometimes known — and there likely will be a virtual component. "Certainly, Internet registration is one of the strategies we will be looking at very closely," Harkin adds. "We will be looking to integrate various customer touch points, and those undoubtedly will include the Web. We will look at it from a people, process, and technology standpoint."

It's about time that health care joins the hotel and airline industries in contemplating consumer management systems, points out **Jack Duffy**, FHFMA, Scripps corporate director for patient financial services.

"Finally, health care is starting to awaken to the fact that we do a less than stellar job in this area," he says. "We put 'Suzi' in charge of radiology scheduling, and a customer calls at noon, when Suzi is going to lunch, and the quality of service declines. We must train to a different level."

There is potential, Duffy adds, for a high degree of integration of access — traditionally a blend of telephone and face-to-face communication — with a lot more telephonic contact and a growing dependence on the Internet.

"The access department will come in as editor," he says, "and there will still be some face-to-face traffic. I'm not sure which term — 'access services' or 'customer fulfillment center' — will dominate."

## *Pinpointing customer access*

The first stage in putting customer-focused strategic plans in place, notes Harkin, is to determine where the customer touch points are in an organization and with what degree of effectiveness they operate. She suggests asking the following questions:

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Editor: **Lila Margaret Moore,** (520) 299-8730.
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@medec.com).
Managing Editor: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@medec.com).
Senior Production Editor: **Terri McIntosh**.

**Editorial Questions**

Questions or comments?
Call **Lee Landenberger** at (404) 262-5483.

1. Is your health care organization presenting a unified image to its various stakeholders, or does the image vary with the contact point?

2. Are there defined standards for various types of contact, such as e-mail, standard mail, fax, telephone, and face-to-face? For example, are faxes answered immediately while e-mail languishes for a week or more?

"You must determine what you have before you can determine how much effort and systems change it will take to build what you want," Harkin emphasizes.

### *Simplify for patient satisfaction*

What *is* new about customer relationship management in the health care market, she says, is that focusing on the customer includes having the ability to manage all interaction channels through which the customers contact your organization.

"Health care is notorious for its separate data silos that don't talk to one another," Harkin notes.

> "Health care is notorious for its separate data silos that don't talk to one another."
>
> Nancy Harkin, Superior Consultants

"It is no longer acceptable for patients to repeat demographic information to each agent along the line as they are transferred from department to department. Technology is the catalyst that enables individuals throughout the organization to be more efficient and effective in their interactions with customers," she continues.

"CRM is becoming the standard for competitive survival," Harkin suggests. "You must have the right tools and the right information in front of your people, or they will be unable to perform as effectively as their CRM-empowered competitors."

*(Editor's note:* Hospital Access Management *will feature an in-depth discussion of the Scripps-Health customer fulfillment center project in a future issue.)* ■