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IN THIS ISSUE

Get surging bad debt under control with these turnaround strategies

Be proactive to avoid problems

Uncollectible funds, or "bad debt," is a problem your patient access department can't afford to ignore. With increasing numbers of self-pay, uninsured, and underinsured patients access managers should revamp processes sooner rather than later.

"Too much bad debt means you probably have faulty operations," says **Joseph Ianelli**, senior financial manager of Boston-based Massachusetts General Hospital's admitting department. "Getting it under control really starts at registration. Making sure that your registrars are well trained and doing lots of QA on registration is your first line of defense."

Tallahassee (FL) Memorial Hospital has seen a surge in bad debt dating back to the onset of the recession. "At that time, we decided to do some proactive work," says **Joan S. Braveman**, director of patient access and financial services.

The first step was to develop a sliding-fee scale for uninsured patients, based on current income and family size only. In many cases, these patients weren't qualifying for public benefits because the criteria looked at their assets and yearly income to date. In contrast, the hospital's sliding-fee schedule guidelines consider only current income.

Based on that criterion, many newly unemployed individuals can be offered a cash discount of up to 90%. Even if patients don't qualify for any discount, they can still be given a prompt-payment discount of 10%.

Another important realization for patient access, says Braveman, is that "the cash that we let walk out the door really diminishes in value. While at some point in the history of health care we could have counted on 85% of that being collected, we're now collecting only about 30% of that." For this reason, the department set out to improve its processes for upfront collections with these steps:

• Price estimation software was implemented, so registrars can tell patients their liability at the time of scheduling.

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"That's been a huge culture change. We do continue to hear from a lot of people, 'They just always billed me,'" says Braveman. "But there are no surprises any more. We're able to ask them to bring the money with them when they come in."

• Registrars use scripting to direct patients' focus to their insurance coverage.

If a patient is confused by a copay or co-insurance, staff try not to get in a position of arguing with the patient. Instead, they just tell patients exactly what their benefits handbook says about their coverage.

"We quote back to them where it clearly states they are responsible for whatever their copay and co-insurance is. One of the HMOs even goes so far [as] to say that payment is due at the time of service," says Braveman. "We explain that this is not about the hospital being money-hungry, as some people may want to believe, but about the contract between the patient and the insurance company."

To bring this point home, staff use wording such as, "Your insurance company has notified us that your liability for this visit is X number of dollars."

"That is helping, but it takes awhile to change a culture that was 60 years in the making," says Braveman. "Since Oct. 1, 2009, which is when our fiscal year started, we have increased front-end cash collections by 50%. It's been a slow, steady rise every month. And a lot of those dollars would have been bad debt."

• Determination of eligibility for charity happens sooner.

"Given a choice of charity or bad debt, I'll take charity," says Braveman. "If we've got a patient in-house who looks like a potential charity patient, we start the process right there. If family members can bring in tax returns or W-2s, we can have a really good sense what this will look like at the end of the day."

A newly unemployed person's assets are often too high to qualify for Medicaid. However, if one hospital bill exceeds 25% of the patient's annual income, then the hospital's charity guidelines are met. For this reason, an effort is made to identify patients who may qualify for charity sooner in the process.

Until four years ago, the charity application process began after the patient was discharged and the final bill was produced. "Now, we begin the charity process as soon as we identify an uninsured person who may qualify," says Braveman. Usually, this occurs at the time of admission, although some patients have qualified prior to service delivery.

"Oftentimes, we'll send an account to bad debt because the patient is just not working with us. Then a year later, they see it on their credit report and claim they never heard about it," says Braveman. "There are times when we end up going back to the point in time when they incurred the bill, and they in fact would have qualified for charity."

Scripting is used by Tallahassee Memorial's registrars to emphasize that staff are there to help the patient. "There is a difference between our recently uninsured and long-term uninsured,"

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notes Braveman. "The newly unemployed, at least in this community, tend to be almost embarrassed to be asking for help. They are more than happy to do anything we ask of them. This is very different from a patient with a credit score of 400 who is not concerned about the credit score impact."

Don't overlook follow-up

Patient access staff at Massachusetts General have many options to help patients with financial problems, due to a generous public benefits program including expanded Medicaid. However, none of this helps a patient unless he or she is deemed eligible.

"Some states may not have as developed a network of public benefit programs as we might have, but most hospitals do have discounting and payment plan arrangements," says Ianelli. "Getting the uninsured and underinsured as engaged as early as possible in the relationship will minimize bad debt."

In order to do this, though, financial counselors need to be able to navigate complex insurance and public benefits requirements. "Whoever is doing that really needs to know how to access public benefits. And I think that they need to be held accountable for following through," says Ianelli. While in many hospitals the financial counselors take more of an administrative role of filling out paperwork, he feels strongly that a more hands-on approach is needed.

"They have to understand how to really access programs and get patients on. Otherwise it's just too hard for the patient," says Ianelli. "The bureaucracies are really tough. It's hard enough to navigate a hospital system, let alone any sort of Medicaid system. So financial counselors really need to elevate their game."

Instead of having financial counselors report up through the back end and billing, at Massachusetts General, they report up through the admitting and access departments. "We really take the philosophy of getting people as much access to medical care as possible," says Ianelli. "I understand that we are in a lucky position compared to many other states, but a lot of states have different variations of free care programs. There are lots of things that people can do."

If financial counselors wait until the service has already happened, an opportunity may be lost. "We try to engage patients right at the point of scheduling and not wait for the patient to actually arrive," says Ianelli. "If folks are aligned with bringing in as many people as possible, rather than keeping them out of the doors, it's better for everybody involved."

Motivate staff

A profit-sharing program at Tallahassee Memorial rewards all colleagues when specified goals are met for the organization as a whole and for each individual department. For the patient access and financial services departments, total collections, both patient and insurance, are used to measure achievement and participation in profit sharing. "That is our carrot. Last year, payment was significant," says Braveman. "Our staff are well aware that cash collections is one of our measures. Receiving that incentive becomes a group motivator."

In the emergency department, the supervisor posts the amount collected by each staff person the previous week. "So it's become a very public number," says Braveman. "If a minimum amount is not collected, she meets with that person one on one. At this point, we are not taking any corrective actions for failure to achieve the goal. We do understand that we've got a whole community to educate."

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Is your verification process up to par?

Are you certain the patient's insurance is actually active? The earlier in the process you learn this information, the more likely you are to avoid bad debt.

"Especially in the ED, but really anywhere, patients are often not in tune with their insurance and how it all works. A lot of patients come into the hospital thinking they have insurance eligibility that might have terminated for some reason," says **Joseph Ianelli,** senior financial manager of

Boston-based Massachusetts General Hospital's admitting department.

The department has taken a strong stance that authorizations for elective admissions "need to be all sewn up and done" before the patient comes in, says Ianelli.

"You don't want to obtain authorization too far in advance, because people do go on and off insurances. But you do need to start the authorization process at least five to seven days in advance, depending on the insurance company," says Ianelli.

The cutoff point is two days before the patient's admission. If there isn't an authorization at that time, staff contact the provider's office to communicate that there may be a problem with the insurance company. "It could be that the insurance company is saying the patient doesn't meet the medical criteria. If so, then we need to get the doctor engaged," says Ianelli. "It's really unacceptable to tell the patient the day before that you can't do the service."

Another obstacle might be that a clinical test is being requested by the payer. If you wait until the day before to find out why the test hasn't been done, that claim will end up being denied. Cases like this are fairly rare, comparative to total volume. However, when they do occur, a physician may need to get on the phone to explain that the test was done previously, or can't be done for a medical reason.

"So you are running into very tight time frames for insurance verifications. But it's an important way to eliminate bad debt," says Ianelli. "You don't want to hear two days after you do the surgery that you're not going to get paid. Then it becomes somebody else's problem in credit and collections. The revenue may be denied or delayed for months and months because of an appeal process." ■

Do you think this patient is going to pay the bill?

Software takes out the guesswork

Patient access staff at Tallahassee (FL) Memorial Hospital are about midway through implementing new software, which **Joan S. Braveman**, director of patient access and financial services, says "will really take us to the new level."

This software does an address and credit check at the time of registration. "Right now, we have a lot of patients who don't even give us their correct addresses in the emergency department, and in our urgent care center as well," says Braveman. "And we have a very educated uninsured population. When asked for ID, they claim they don't have any with them and tell us, 'Well, I'll just go to the emergency department because you have to take care of me.'"

As a patient was being registered under one name, the triage nurse noticed he already had a wristband on. "It was from another hospital in town and had a totally different name on it," says Braveman. "Ultimately, that account goes to bad debt and you have no way to get ahold of the patient."

The new software provides some defense against situations like this. It uses many different databases from retailers and credit reporting agencies to verify that the patient's stated address is correct. If the patient actually has another address on file, this is flagged on the screen.

"It comes back to you with a pop-up saying the patient actually lives at this address. Then we have an opportunity to say to the patient, 'Is there another address I might find you at?' Of course, some people are going to tell us no. But for the most part, I think it's going to work well," says Braveman. "We'll have a valid address we can send a bill to."

Resources are prioritized

For each patient, a "propensity to pay" indicator is given, using a red, yellow, or green light. This is based on several factors, including the patient's credit score and his or her history of paying medically related bills.

"A red light means that the patient will never pay the bill, a green light means you can count on it, and yellow means it's kind of iffy," says Braveman. "This helps staff to prioritize their work."

For a "red light" patient, staff might ask providers whether the service is actually needed that day, or whether it could be scheduled for a future date after the patient is able to pay for the service upfront. "We're primarily doing that for very expensive things, but we will start doing it across the board," says Braveman. "We will only cancel with the physician's permission, and we're obviously never going to deny anyone medical services that are urgent."

If a patient has a green light, he or she is offered

a prompt-payment discount. "And obviously, our prediction is we're going to get the money right now," says Braveman. "That will help us on the front end. It will also help us on the back end, though, because we won't spend a lot of time with 'red light' patients."

For uninsured patients who are approved for Medicaid, the system can request a 90-day look-back. This means that if the patient had an uncompensated service during that time frame that went to bad debt, the hospital can now get paid.

Likewise, if the patient isn't approved for Medicaid at the time the service was done at Tallahassee Memorial, but is approved for Medicaid within the next 90 days, the hospital gets paid, even if this occurs in a different city or state.

The "yellow" patients are where most of the staff's attention is directed, since there is a good chance their interaction can result in additional payment. "You never know why a person is 'yellow,' and so, that is exactly where our energy is going to go," says Braveman.

If a patient is recently unemployed, for instance, he or she might qualify for charity, or a patient can be made aware of the hospital's discount policy. "That, to me, is one of the most intriguing features of the system," says Braveman. "Because right now, when the customer service people are calling patients, all they know is if the patient owes us money. They don't know a lot more than that."

Knowing something more about the patient, even if it's only that they have a "green" indicator, meaning a good credit history, helps to direct the call. "On the business office side, we can get all the way to the detail of their credit report. But obviously, for confidentiality reasons, we would not make that information available to all of our staff," adds Braveman. ■

Combined roles means a streamlined process

Patients are helped right away

If a patient becomes upset about the amount he or she will owe, **Joseph Ianelli**, senior financial manager of Boston-based Massachusetts General Hospital's admitting department, says that the message patient access staff want to give is: "There is something we can do for you. We want you to get the medical care you need."

About five years ago, the department integrated registration with financial counseling as part of a major redesign of front-end operations. "It made sense to start consolidating those roles," says Ianelli. "It's a higher job grade, and a more sophisticated approach that we are using. We have to look for people who have the skills to do both."

If a patient is having problems with eligibility at registration, he or she can start a financial counseling process, right then and there.

"Nobody has to wait in line all over again. They don't have to figure out where to go or what else to do," says Ianelli. "Staff members 'own' a caseload, and we have a database that tracks that. As long as a patient is cooperating and communicating, we will do whatever we can for them."

Process starts earlier

If the scheduling secretary puts into his or her system that a patient is uninsured, that piece of information gets to patient access staff right away. "We don't have to wait until the patient comes in to start the financial counseling process. We can start the process five or six days before they walk in for their appointment," says Ianelli.

A patient might be asked to bring in certain documents, or to go see patient access right before the appointment, and staff will finish up the process in the meantime. "Our patients need to focus on medical care and getting better," says Ianelli. "So staff are really held responsible for making sure those applications either get approved or legitimately not approved because they don't qualify for the program."

Individualized help

Financial counselors are expected to know the full range of options for patients. This includes understanding the internal policies and procedures of the hospital for discounting and payment plans. Or, it may be that there is some type of insurance coverage that the patient has access to but is unaware of.

"If there is a couple and the husband has insurance, why isn't the wife on it? It could be time for a conversation about the next open enrollment period," says Ianelli. "Or if someone has Medicare A, why don't they have Medicare B? Or if prescriptions are a problem, somebody may qualify for Medicare D."

An escalation process is used for difficult cases, such as patients with very large debt who don't qualify for public benefits or charity. "No hospital should want any of their patients to become destitute because of their need for medical services," says Ianelli. "It tends not to work that way; but it if does, I will raise the issue to upper-level administration with a full write-up and analysis."

At that point, a discussion can be held about what exactly can be done for the patient. A range of options is identified. The payment plan might be extended beyond the standard as part of an individual consideration due to financial hardship, for example.

"We start to talk about what would be reasonable this one time, on a case-by-case basis. But decisions are made based only on financial hardship. Otherwise, you run into some tricky compliance issues," says Ianelli. "You always want to do things completely above board. You can't have special arrangements for one person that you don't make for everybody."

Still, there is a great deal that can be done for individual patients. A woman in her 70s who worked for the state had a number of different insurances. She couldn't comprehend her coverage, such as why the secondary insurance wasn't picking up certain bills. After many unresolved phone calls to customer service, the situation was escalated to Ianelli.

"For some reason, the folks she was interacting with couldn't make any headway with her," says Ianelli. "So over the next six months, she and I worked together to understand her insurance and her bills going back for many years, and I was happy to do it. It's really all about developing a continuum of relationships from front to back, and working together to support the patient." ■

Are registrars accountable for registration mistakes?

Without question, the mistakes made by front-end staff can make or break the success of your patient access department. "Registration is one of the important components of patient care," says **Debra A. Artwell**, manager of outpatient access at Pennsylvania Hospital, part of the University of Pennsylvania Health System. "The patient demographics and financial information are data that follow the patient throughout our entire health system."

In some cases, though, registrars may be completely unaware of the costly mistakes they're making. If this is the case, it's a safe bet the mistake will be repeated again and again.

"If staff are not aware of the errors they're making, they can't impact their own performance. They can't attain the goals for performance that are set for them," says **Tammy Casados**, patient access manager at St. Anthony Central Hospital in Denver.

"In most instances, registration staff have first contact with our patients," says **Anne Goodwill Pritchett**, vice president of patient financial services at Hackensack (NJ) University Medical Center. Their responsibilities include capturing patient demographics, verifying insurance eligibility and benefits, and obtaining pre-certifications and authorizations that may be required to obtain payments from insurers or third-party payers.

"If any of these data are incorrect or inaccurate, it creates a negative rippling effect throughout the revenue cycle," says Pritchett. "Inaccurate data can results in denials, payment delays, bad debt, and patient dissatisfaction. Hence, it is imperative to hold registration staff accountable for their own errors."

Pritchett says that the biggest challenge is the lack of user-friendly, real-time technology to do this without manual intervention. "While there are some online tools available, most that we have seen are not comprehensive and require some manual manipulations," she says.

Get fewer denials

When staff are held accountable for errors, there is less likelihood of denials and lost revenue. "Clean claims go out the door on the first attempt. That will decrease our A/R days and help our cash flow," says Casados. "Regulatory compliance is achieved, which contributes to accreditation of the facility during reviews."

These changes were made by patient access managers at St. Anthony's:

- **Staff make their own corrections to their work, so they can learn from their mistakes.**

This way, the ramifications of incorrect demographic and insurance information entered at the beginning of a registration become very clear. "This decreases correction at the back end and

results in timely filing with the insurance companies," says Casados.

If the staff person who made the error happens to be off when it's discovered, it's corrected by a manager and reviewed with the registrar later. The same process is used if there is not enough coverage in the registration area and the staff are too busy with patients to correct the error in real time.

• Registrars are audited on their performance in the department.

A goal is set for each registrar that the error ratio needs to be less than 5%. Statistics are posted on the department's monthly collections and registration accuracy rates. "The staff see how well we're doing as a unit and what we need to improve upon," says Casados.

• The staff meeting area was converted from a conference room setting to a training room setting.

"Now, instead of booking a conference room for our meetings, I place a request for one of our training rooms," says Casados. "We have a classroom set up with computers in the room and access to overhead projectors for PDF file viewing."

A recent staff meeting covered Advance Beneficiary Notice of Noncoverage (ABN). Each registrar was given material on how to enter the ICD-9 procedure code. If they made a mistake, they were asked to correct it on the spot.

"On their failed ABNs, they had to follow the process. They had to explain the ABN form to the patient, enter the ABN code showing the patient was provided the form, enter the occurrence code that the ABN failed, and scan in the failed ABN," says Casados.

Staff have access to training modules on computers and can create registration scenarios anytime. Share drive folders were created for patient access staff, so they can review policies and procedures and updated changes on payer requirements.

"Any information that pertains to patient access can be found in our share drive folders," says Casados. "During our staff meeting, when discussing any new changes, we can pull up the policies or procedures. Staff are engaged, and the changes can be discussed in that setting."

Give specific goals

The expected accuracy rate for all of Pennsylvania Hospital's patient access staff is 95%. "Our registrars are continually reminded that system entry affects patient safety and the revenue cycle of the health system," says **Lurie V. Forney**, manager of quality and training.

Managers critique a percentage of each registrar's accounts. Their accounts also are evaluated by their colleagues using a peer review process.

In addition, accounts are monitored to check for duplicate medical record numbers, misidentified patients, and the inclusion of universal index numbers, which are unique patient identifiers.

"Some of our challenges are the increased number of patients we are seeing, and the registrar's increasing responsibilities as we continue to expand our services," says Forney "Also, there are language issues, the limitations of patients as historians, and the patient's willingness to divulge information."

The patient may not even be present to confirm all the information. "The staff are relying upon information that has been sent by physician offices, which may not always be accurate," says Artwell. "Our registrars possess exceptional investigative skills. The focus is reimbursement and accuracy," says Forney.

To motivate staff, incentives are given for the least amount of duplicate medical record numbers created and the most copays collected. The department has found that holding staff accountable does more than just reduce mistakes; it also increases their independence and self-confidence. "Also, self-reliance and respect for managers improves," says Forney.

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Give assessment tests if these errors occur

Registrars are given two assessment tests each month, covering updates to policies or payer requirements, at St. Anthony Central Hospital in Denver. If someone fails a test, the department's patient access coordinator does a one-on-one educational session, and the test is retaken. Here are items that staff have been tested on:

• **The hospital's stroke alert process.**

The steps that occur when the emergency department receives the call that a stroke patient is on the way were reviewed. First, a "John/Jane Doe" visit, because the patient's name is not yet known, is created with an account number medical record attached. "Once the person rolls in, we can update the time they arrived and collect demographic information," says **Tammy Casados**, patient access manager. "If the patient has been here before, we will contact medical records to combine the new medical record number to their old medical record number."

• **Police/state patrol registration.**

"The registration staff were automatically billing the police or state department," explains Casados. "We needed to ask the police and state patrol office some key questions, to see if the patient or the police or state department needs to be billed."

• **Acquiring physician information and data entry.**

The importance of collecting the primary care and referring physician's contact information was explained to staff. "This is very important for the patient's care, just in case the ED or admitting physician needs to talk with the patient's primary care or referring physician about their plan of care," says Casados. "This also helps case management on placement."

• **Correctional facility registrations.**

A PDF file was put together on how to handle correctional facility inmates. Staff were reminded to follow all processes for their safety and to avoid giving out personal information.

• **Insurance payer codes.**

The most common errors received back from the central billing office were reviewed. "Some of these involved updated insurance changes. These can be reviewed with the registrar or financial counselor to find out why they used a particular code," says Casados.

• **Duplicate medical records.**

When it's necessary to create a duplicate medical record, such as a stroke alert that starts off as a "John/Jane Doe" visit, an e-mail is sent to health information management (HIM) to let the department know why the duplicate medical record was created. "This will prevent the registrar receiving a error," says Casados. "No notification to the HIM department will lead to an error."

Feedback on errors

Coordinators were hired to do daily audits on registrars based on their daily activity log. "They can address errors or go over a process that isn't being followed," says Casados. "They can give feedback to the registrar during their working day on their work activity." The coordinator is able to work with the team on any issues that occur in the department.

Recently, the coordinator had to correct an incorrect entry for the "reason for visit" field for an admitted patient. "Our super census team was trying to get the authorization for the patient's visit and needed a correct reason for visit, chief complaint, or diagnosis," says Casados. "We can run a report to see if we have a valid reason, update the field, and educate the staff."

The coordinator can run a pre-edit bill at any time showing all errors that would hold up a statement, such as incorrect Medicare information. "We can remove the Medicare from the patient's visit and educate the staff on what they did wrong," says Casados. "For failed ABNs, we can see if the registrar completed the form, if the patient signed and dated the form, and if they updated the pending code," says Casados. "Also, we can check to see if they added the occurrence code."

A productivity report is run for each registrar. This tracks each patient checked in for the day, to ensure all demographic and insurance information was collected. "We run a consent audit daily on all registrars. We look to see if the HIPAA box is marked, if the name is printed on the form, and that the signature, date, and time are listed on the form," says Casados.

Payer code corrections may involve use of a generic payer code instead of a specific payer code. "This shouldn't occur, but we can find out why," says Casados. "The reason could be they saw an out-of-state address that didn't look familiar and chose the generic payer code, when in fact we do

have a payer code for out-of-state coverage for the insurer."

Recently, Casados noticed that the incorrect payer code was being used 99% of the time for a certain insurer. "I put an assessment test together, with all payer codes attached," she says. "Now, they can go to the share drive folder under 'insurance,' and match up the card they are looking at to the correct payer code."

Missing scanned orders was another issue. Staff were educated about the key elements for a valid order and told that the patient isn't to proceed to the department of service without a valid order. "We made changes at our central scheduling department to ensure that there is a valid physician order when booking appointments," says Casados. "If the office didn't get us an order, the scheduled booking would stay in a pending status until the order was received." ■

Eliminate costly gaps in your authorizations

It sounds fairly cut and dried: If an authorization isn't obtained from a payer, the claim will be denied. However, payer requirements are getting more and more complex and stringent.

"More plans are requiring authorizations that were not previously required," says **Helen Thomas**, manager of financial counseling at MUSC Medical Center in Charleston, SC. "More and more procedures are now requiring authorizations where they were not required in the past."

Payers also are asking for more documentation to be provided upfront before they authorize a service. "It is not always readily available," says Thomas. "It can require the use of many hospital systems to secure what is needed by the carriers."

Both diagnosis and CPT codes often are requested for processing, which typically are not readily available. Also, with the move to privatizing government payers, HMOs for Medicaid and replacement plans for Medicare want authorizations on procedures that were not previously required.

"That in itself takes more time in the work day," says **Marlene Haselden-Mizell**, manager for patient access services at MUSC's main hospital.

The patient may also come in with one planned procedure, and while services are being provided, an additional or new procedure is performed. This impacts the authorization number. Another challenge involves patients coming in with a number of different insurances, with each plan requiring something entirely different.

Here are some strategies implemented in MUSC's patient access department to close "gaps" in the authorization process:

• Authorizations are obtained for "add-ons."

At MUSC, one of the biggest challenges for patient access services/registration is the last-minute "add-ons" for radiology and interventional radiology. Procedures may be scheduled on the same or next day, while most insurance companies require a minimum of 24 to 48 hours to secure the authorizations.

"Depending on the time of the procedure, financial counselors may not have seen the request," says **Lisa Cooper**, manager of patient access services for ART/emergency department. "Several insurance companies require that you go through a third-party vendor for authorizations." Most of the third-party vendors require 72 hours before authorization can be obtained.

In this scenario, the patient has one of three choices. He or she can postpone the test or procedure until authorization has been obtained. This can be a problem for patients if they live out of town or require additional lost time from work. Or, they can wait while a financial counselor tries to obtain the authorization, which puts the technician or physician behind schedule. Lastly, they can pay out-of-pocket.

"None of these solutions make for a 'wow' customer service experience for our patients and staff," says Cooper.

• More frequent updates are given about payers.

"We are meeting monthly to keep staff informed of the changes in insurance requirements and updates from carriers," Haselden-Mizell says.

• A system is in place for length-of-stay changes.

The patient may be an outpatient at the time of admission, but this can change to observation status and then to inpatient status. Thus, a new authorization is required.

• Staff communicate with various departments within the hospital.

This is to ensure they're aware of the various time requirements of the insurance companies as they schedule appointments, says Haselden-Mizell.

• Claims denials are evaluated.

"We determine why the case did not get authorized and how to fill that gap so it is not repeated," Thomas says.

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Put a stop to complaints on call center wait times

Patient access leaders at St. Joseph's Hospital Health Center in Syracuse, NY, knew there was a perception by some people that scheduling medical imaging procedures was difficult. What they didn't know was why.

"Until we surveyed our physician offices and reviewed a year's worth of call data, we could not identify the root causes for this perception," says **Carol Triggs**, MS, director of patient access.

Last year, senior leadership identified five clinical and nonclinical processes that provided opportunities for improvement. Each of these was important in support of the hospital's mission, vision, values, and strategic plan, and provided a potential return on the investment.

One of the projects looked at all outpatient procedures scheduled for computerized tomography scans. After a data analysis, several root causes were identified, which could potentially cause barriers to efficient scheduling.

These were lack of available time for the procedure, the need for additional calls to obtain clarification about procedures, lengthy wait times before calls were answered by centralized scheduling, inadequate staffing, and increased call volumes at certain times.

"We determined which steps in our current processes were value-added for the customer, versus those steps that were non-value-added. We worked to eliminate the non-value-added steps," says Triggs.

An example of a value-added process for the customer is the time spent "reading back" the procedure, time, and location to the caller as a confirmation. An example of a non-value-added process was the time the customer was placed on hold during the call while scheduling contacted medical imaging to clarify a procedure request.

The improvement team assembled for each project followed a Lean Six Sigma systematic approach to problem solving. This involves five steps: define, measure, analyze, improve, and control. Here are the steps that were taken during each phase:

Define: The problem at hand is characterized and depicted as a "process map," which is a high-level flow chart of the process steps. "The value of the tool is to define the boundaries of your process and help you make sure the goal of your project is not too broad or too narrow," says Triggs. "You do not want to bite off more than you can chew with just one project."

In this phase, the cost of poor quality, which becomes the basis for the return on investment, is calculated. This was done by assessing the time spent by both the scheduler and the CT during the additional calls that were made from scheduling to medical imaging.

"We also looked at the percentage of calls that were abandoned before the scheduler was able to answer the call, and translated that to potential lost revenue," says Triggs.

Measure: Baseline data are collected on the process in question. The goal is to help understand the extent to which energy, time, or resources are wasted. Key metrics used to analyze opportunities for improvement included the average wait time for calls to be answered, the percentage of calls answered within 50 seconds, and the percentage of calls that were abandoned before they were answered.

"Through the data collection process, including surveys with physician offices and an analysis of call center phone data, the team was able to determine where the process could be improved and developed an implementation plan," says Triggs.

Analyze: The actionable root causes of the poor process performance are identified. The most critical of these root causes are selected as a target for improvement.

"Our most critical root causes were the call wait times and the additional calls that were made from scheduling to medical imaging during the scheduling process, which incurred an increase in 'hold time' for the caller," says Triggs.

Improve: The improvement strategy is selected. A plan is established for piloting on a small scale. The process improvement plan included three components:

1. The schedulers' work flows were restructured to better serve patients during peak volumes.

"We altered break times and lunch times to meet these needs," says Triggs.

2. The volume of calls that had to be made by scheduling to imaging during the scheduling process was reduced.

These calls were made to either clarify proce-

dures or to "add on" patients for the same day. "Our medical imaging department developed cheat sheets, so the physician office staff could more easily identify correct procedures," says Triggs. "We also created interactive view ability in our software system for the scheduler to identify open slots for add-on patients."

By doing this, extra calls made to imaging to schedule add-on patients were eliminated.

"We piloted these changes over two months," says Triggs. "Although we saw substantial improvement in our call wait times, we are not yet at our goal."

3. A secretarial position was added.

This freed up a scheduler from secretarial duties. The secretary collates all documentation faxed into scheduling for surgical and invasive procedures.

"The documentation received from the physician offices is checked against our software system, to ensure that the written orders match the orders in the system. This includes pre-admission testing orders," says Triggs.

Control: Methods are established to track the process and sustain its improvements. Weekly tracking of metrics is performed by the manager to ensure goals continue to be met.

"We are tracking the department's weekly average call hold time and the percentage of calls answered within 50 seconds," says Triggs. "These data are shared with the schedulers on a weekly basis. A monetary monthly incentive plan for our schedulers was implemented in 2010, based on attaining the designated goals in each category."

Scheduling streamlined

The team's overall goal was to streamline the scheduling process for medical imaging, by decreasing inefficiencies within the process. "Our results within the first six months have exceeded our initial expectations," reports Triggs. Since August 2009, the average wait time for a call to be answered by centralized scheduling has been reduced from 38 seconds to a current average of 12 seconds. The percentage of calls answered within 50 seconds has risen from 73% to 94%.

"Our abandoned call rate has decreased from an average of 9% down to an average of 2%," says Triggs. "The improvements in response time are measured for all calls to centralized scheduling, not only medical imaging." Thus, these improvements translate to all services, both diagnostic and surgical.

"We learned so much through this Lean Six Sigma project. Most importantly, we learned that the front-line folks make all the difference," says Triggs. "It was critical that all of our schedulers were engaged in the process and project. They are the ones who do the work day to day and can ensure sustainability."

For instance, schedulers were the ones who identified the bottlenecks in additional calls being made to medical imaging during the scheduling call. "We would not have known this without their input," says Triggs. The schedulers also worked closely with medical imaging in creating the cheat sheets, so the physician office staff could more easily identify correct procedures.

"Their input was critical to us finding the root causes for the additional calls and eliminating those causes," says Triggs. "Their continued engagement with the process improvements has been critical to our ability to sustain these results."

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ID software means less chance of identity theft

Over the past several years, patients repeatedly told registrars at Bay Care Health System — a Tampa, FL-based system consisting of 11 not-for-profit hospitals, outpatient facilities, and services — that they were concerned about medical identity theft. They didn't want to provide sensitive identifying information, such as Social Security number, each time they accessed the facility.

These concerns were one reason that the hospital system chose to invest in a patient identification

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system, which integrates with the department's electronic medical record system. Patient records are now brought up with the scan of a palm, with no need to give out personal information.

"This results in continuity of care and avoids unnecessary tests," says **Candace Gray**, director of admitting and registration. "Patients also can be quickly identified in case of an emergency, without having to say anything. We once had a patient come to one of our hospitals and we were able to pull up his previous information and notify his family."

Duplicate patient records are less likely to occur, and there's less chance of the misuse of Social Security numbers and insurance cards. Patients are quickly and accurately registered, with fast and simple return visits. "These return visits do not require sharing patient identification information," says Gray. "There is greater accuracy, with less information shared. It also guards against identify theft."

Patients like it

"The response from our patients has been overwhelmingly positive," reports Gray. "We enrolled 360,000 patients in the first year and a half, and the patients' compliance rate is over 99%. It's easy for staff to use and helps them pick the correct patient if the patient is already enrolled."

The surge in medical identify theft has made patient identification technology a "must have" for patient access departments. "As more and more health systems and other health care providers implement electronic medical records, technology such as palm scanning is crucial to help positively identify patients and ensure continuity of care," says Gray.

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