Hospital Access Management™

Admitting ● Reimbursement ● Regulations ● Patient Financial Services ● Communications
Guest Relations ● Billing & Collections ● Bed Control ● Discharge Planning

August 2010: Vol. 29, No. 8
Pages 85-96

IN THIS ISSUE

Make needless claims denials a thing of the past with staff involvement

Turn mistakes into a 'teaching moment'

Too many claims denials lead to loss of revenue and unhappy administrators — two things no patient access department can afford, especially in this economy.

"Denials from commercial carriers are always a challenge," says **Frank Danza,** vice president of revenue cycle management at North Shore-Long Island Jewish Health System in Great Neck, NY. "Our patient access areas must be diligent to make sure we have accurate insurance and proper authorizations on every case."

Danza says this is true for all points of access, whether a case is scheduled, emergent through the ED, or transferred from another facility. "Each situation presents its own set of challenges," he says. **(See story on the organization's ED "exit process," page 87.)**

Revamp claim review

At Good Samaritan Medical Center in Brockton, MA, the patient access department recently upgraded its denial management system. Claims for all payers are now reviewed prior to submission to the insurer.

"We started slowly, with only a couple of payers," says **Eric Akesson,** director of patient financial services. "We noticed a decrease in denials and an improvement on the overall speed in which claims are processed for these payers."

Akesson says he expects this to continue as the use of the tool is expanded. "The data received on potential denials have also been very helpful in educating staff on recurring errors," he adds.

According to Julianne Flammia, the hospital's director of patient access, the biggest problem from an access standpoint is that incorrect insurance information from a previous visit can occasionally be retrieved and used multiple times.

"If your system carries forward incorrect demographic information

AHC Media LLC

to future visits, the problem will be compounded on multiple visits," says Flammia. "It is imperative to have a tool in place to verify all insurance data at the time of scheduling or registration to reduce these denials."

Staff correct mistakes

Good Samaritan's patient access department uses a system with quality assurance functionality that monitors eligibility and verification errors prior to claim submission. These errors are self-reported, and corrected by the patient access coordinator prior to the claim submission.

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 740059, Atlanta, GA 30374.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions
Call Jill Robbins at (404) 262-5557

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: Stacey Kusterbeck, (631) 425-9760.
Managing Editor: Jill Robbins, (404) 262-5557, (jill.robbins@ahcmedia.com).
Executive Editor: Russ Underwood, (404) 262-5521, (russ.underwood@ahcmedia.com).

"The registration staff are so busy and under tremendous pressure to register a patient quickly and accurately," says Flammia. "Correcting their own errors helps the staff to recognize the correct mnemonic to use, how a policy number should be entered, and how it should look. They will learn the proper way an insurance must be entered."

Reports are created for individual staff members, showing the type and amount of denials received. "These data can then be used to conduct a teaching moment with the individual regarding these mistakes," says Flammia.

Previously, claims denials were corrected later in the process by the billing office. Thus, the access staff who made the mistake were out of the loop. "Communication between both departments will help to educate the front-end staff going forward," says Flammia.

By reviewing claims before they are sent to the insurer, the facility is alerted about a potential denial based on the specific provider requirements. "This helps keep total denials at a minimum, though you will never be able to completely remove denials from the billing cycle," says Akesson.

Akesson says the most important feature is a tool that reviews multiple payers that is supported on a regular basis as insurers are constantly changing their requirements.

"If you do not stay current with these changes, you will definitely see an increase in your denials, no matter how robust your original tool was," says Akesson. "A tool needs to be updated on a regular basis to catch all of these changes." (**See story on what to look for when investing in technology to manage claims denials, page 88.**)

Proven approaches

Gayle Dickerson, patient access director at Baptist Hospital East in Louisville, KY, says her department has reduced claims denials with these approaches:

- moving to online verification of insurance coverage at the time of registration;
- verifying pre-certification requirements online, and ensuring these are correct for the procedure being performed;
- having a high percentage of preadmitted patients. "This allows ample time to verify coverage and pre-certifications for scheduled tests, procedures, and admissions," says Dickerson.

At Methodist Charlton Medical Center in Dallas, all scheduled and admitted patient accounts

are reviewed within 24 hours of admission. Staff verify that authorization and referral has been obtained by the financial counseling staff.

"For those insurance providers that we have online access to, we scan the authorization into our registration system," says **Jeanette Foulk,** director of admitting/discharge. "For those that are done via phone, reference numbers are requested." The name of the representative who provided the information is always documented.

For outpatient scheduled appointments, this process is followed:

- A list of all scheduled procedures is printed every day.
- All accounts are verified by management.
- Staff verify that an authorization number has been obtained and is noted in the authorization field.
- Staff verify that a referral has been obtained, if needed.
- If authorization is not obtained, the account is referred back to a financial counselor for completion. It is returned to management when completed, for verification.

For inpatients, a similar process is followed:

- An inpatient insurance worklist is printed.
- All admissions are verified for authorization within 24 hours.
- Staff verify that authorization has been obtained or noted as "pending, due to clinicals requested."
- If authorization is not obtained, the account is referred back to a financial counselor for completion.

Registration and financial counselors have access to a database, which contains updates and changes by insurance plans for easy reference. "It is hard to keep current with all of the payer requirements," acknowledges Foulk.

Involve physicians

Sometimes, authorization is not obtained because the requesting physician failed to contact the insurance plan. "When this occurs, we contact the requesting physician and request follow-up as soon as possible," says Foulk.

If authorization is still not obtained at the time of the procedure, the patient is notified of a possible delay in the procedure due to failure to receive authorization.

"The patient may be asked to reschedule until we receive authorization provided by the referring physician," says Foulk. "The exception to this is if the [patient's procedure] is considered an urgent or emergent procedure."

Dickerson says that her staff work directly with physician offices to verify that the diagnosis covers the test or procedure being performed. "We ensure that the precert matches the test exactly. We make corrections as necessary," says Dickerson. This is sometimes done the day after the test, but always within 48 hours.

"This has proved to be very effective in decreasing denials. There's an exact match, and the claim processes cleanly," says Dickerson. "Also, working with physician offices helps them understand what happens on the hospital side."

[For more information, contact: Frank Danza, Vice President, Revenue Cycle Management, North Shore-Long Island Jewish Health System,145 Community Drive, Great Neck, NY 11021. E-mail: FDanza@NSHS.edu; Gayle Dickerson, Patient Access Director, Baptist Hospital East, 4000 Kresge Way, Louisville, KY 40207. E-mail: Gdickerson@BHSI.com; Jeanette Foulk, Admitting/Discharge Director, Methodist Charlton Medical Center, 3500 W Wheatland Road, Dallas, TX 75237. Phone: (214) 947-7560. E-mail: JeanetteFoulk@mhd.com.] ■

Patients are satisfied with ED 'exit process'

Uninsured are often reassured

Emergency departments across the North Shore-Long Island Jewish Health System in Great Neck, NY, care for hundreds of thousands of patient each year who are treated and released without being admitted to the hospital.

"For these cases, our registrars have relatively limited amounts of time before, during, and after the delivery of care to attempt to secure the proper insurance information from the patient," says **Frank Danza,** vice president of revenue cycle management.

This can be particularly challenging when the patient has been involved in a work-related or automobile accident, where no-fault or workers' compensation rules may apply. Patients may not have brought with them the necessary automobile insurance or employer information.

To assist them in understanding their responsibility in supplying the necessary infor-

mation, each patient is guided by his or her care provider to an "exit process" as he or she leaves the ED.

Demographic and insurance information is validated while patients receive care, so errors can be corrected as they leave. Copay and/or coinsurance amounts also are confirmed. "These can be explained to the patient, and they can settle these amounts before they leave," says Danza.

If necessary, staff confirm automobile insurance or employment information. In the case of an uninsured patient, the financial assistance program is explained, and if appropriate, the patient begins the process of applying for Medicaid.

"We have found that our patients actually appreciate the assistance and clarifications they receive in the exit process," says Danza. "They appreciate that they will not be surprised by amounts billed to them days after they get home."

Uninsured patients, in particular, often leave with a sense of relief. "They know that they are eligible for either a government program or assistance from our health system, which has made their care affordable," says Danza. ■

With claims denial tools, look before you leap

Is it user-friendly?

Is your patient access department considering investing in software to decrease and manage claims denials? If so, compliance and customer service must be considered, says **Katherine H. Murphy**, vice president of access solutions at Nebo Systems, a division of Passport Health Communications in Franklin, TN.

Murphy recommends "one-stop shopping" for multiple features such as insurance benefits, quality assurance, estimates, payments plans, charity assessment, and propensity to pay.

"This makes good sense operationally, since they offer streamlining and continuity to the users," says Murphy. "Of course, we cannot dispute that cost, space issues, storage issues, and adaptation to future technologies that will one day be a replacement must be considered. There is so much to choose from these days."

Card readers, biometrics, and self-service kiosks all play into managing and reducing claims denials when strategically introduced and managed, says Murphy.

Answer these questions

"I have found that assessing the level of intensity of education of the users is highly significant," says Murphy.

If an application is not user-friendly, it "simply will not be used as well and as often as you would want," says Murphy. She says to ask these questions:

- Is it easy to get user feedback to promote better use?
- What problem are you solving? Is it an organizational goal, compliance, or a design flaw of some sort that you are trying to solve?
- Can the technology accommodate local and national legislation requirements?
- Will the automation be efficient in the environment in which it will be used?
- Do the physicians, staff, and patients realize a benefit?
- Is it easy to use? Is a lot of training required?
- Am I paying for bells and whistles that I don't need?
- Do the data need to be managed?
- Is the program customizable without costs?
- What is the implementation time?
- What changes can I maintain?

After implementation

Murphy recommends these approaches after implementing claims denials tools:

- **Don't measure too much.**

"Reporting capability and flexibility is highly significant. Yet, some things that are measurable do not need to be measured," says Murphy. "So beware of measuring fatigue. Seek the right level."

- **Rewrite policies to align with any changes you make.**

"This is the perfect time to update your internal policy and procedures," says Murphy. "Revise the existing processes, and then automate them. Don't automate any existing inefficient processes. They will likely be even more inefficient."

- **Be visible and accessible to all stakeholders.**

"Demonstrate your commitment to moving forward with the technology initiative," says Murphy. "Think about communicating 10 times more than usual."

- **Allow a couple of your department "superstars" to participate in the technology selection process.**

"They can provide a reality check that is necessary to make a best choice," says Murphy. "And keeping true to what we hold dear in patient access, remain service-driven and be the champion of change."

Proven strategies

John Woerly, RHIA, CHAM, a senior manager at Accenture in Indianapolis, IN, says that the most effective way to manage claim denials is through good documentation, accurate procedures, an educated staff, and front-end resolutions.

"Technology plays an important part in both preventing and recovering denials. But it is only one part of the equation," says Woerly. Process redesign, training, and follow-through also are essential components.

Woerly suggests these key processes to effectively manage denials:

- Ensure complete and timely service documentation.
- Improve registration data quality.
- Conduct concurrent utilization review.
- Consolidate pre-certification, authorization, and recertification functions into a single department.
- Share pre-certification requirements with physicians' offices.
- Provide physicians with regular feedback on clinical denials rates.
- Hold regular meetings with payers to discuss denials issues.
- Regularly distribute contract terms to revenue cycle employees.
- Make sure all denials reason codes are actionable.
- Track observation and inpatient authorizations separately.
- Inform revenue cycle employees of contract changes before the effective date.
- Exchange structured feedback between the revenue cycle, utilization review/case management, and managed care departments.
- Schedule non-emergency services 12 hours or more in advance, to help prevent both medical and technical denials.
- Track denials by payer, reason, and financial consequence.
- Distinguish between technical and clinical denials.
- Track denials by physician, DRG, and department.
- Ensure that contractual allowances are increasing more slowly than gross revenue. "This is a check to make sure that A/R is not being written off to reduce days in A/R," says Woerly.
- Have a dedicated denials units with payer-specific appeals experience.
- Respond to clinical documentation requests within 14 days.

Woerly says that tracking performance is the biggest benefit that both revenue cycle and clinical departments stand to gain with the use of claims denials software.

"It is amazing the number of health care facilities that truly have no idea of the number and dollar amount in denials, let alone where those denials are coming from," he says. "Being able to track performance, and then to proactively act upon findings, is essential to denial prevention."

Changing workflows

Murphy says that when claims denials software is implemented, "there will be a higher level of accountability and tracking. This may change workflows and move them from one role to another. This requires strong support from the executive level."

For example, financial counseling tasks may be moved to scheduling or pre-registration areas, since patients may need to reschedule if they are without the proper authorizations. "Working smarter and more timely on issues of a critical nature is a bonus of using such software," says Murphy. "There is less paper."

However, without planning carefully, a patient access department may not reap the hoped-for benefits. "I have encountered folks who have the idea that you just plug it in and it works," says Murphy. "The software must be embraced and managed. It must be maintained."

Murphy says, "Finding the best expertise needed to manage the changes within the organization can be an interesting journey. This is the time to see who steps up to the plate to be the champion."

[For more information, contact: Katherine Murphy, Director — Access Services, Passport Health Communications Inc., 720 Cool Springs Boulevard, Suite 200, Franklin, TN 37067. Phone: (615) 661-5657. E-mail: katherine.murphy@passporthealth.com; John Woerly, RHIA, CHAM, Senior Manager, Accenture, Indianapolis, IN. Phone: (317) 590-3067. E-mail: john.woerly@accenture.com.] ■

Have staff gotten their CHAM or CHAA?

If not, there's no time like the present

Some front-end staff, unfortunately, view your department as a revolving door or jumping-off point. However, others choose to make a long, fruitful career for themselves in the field of patient access.

Obtaining Certified Healthcare Access Associate (CHAA) or Certified Healthcare Access Manager (CHAM) certification is an important milestone for a staff member, and an indication that your employee may be part of the group that's there to stay.

Connie Longuet, CHAM, director of patient access services at the University of Texas M.D. Anderson Cancer Center in Houston, sits on the National Association of Healthcare Access Management's (NAHAM) certification committee. "There are approximately 500 CHAMs and 3,500 CHAAs as of May 2010," she reports. "I got involved because I strongly feel that patient access should be a career choice, not just a job."

Longuet says that as health care is "a very dynamic industry with new rules and regulations constantly being introduced, patient access staff must continually stay on top of the current trends to ensure financial success for their institutions."

When employees obtain CHAA and CHAM certification, employers should celebrate this accomplishment by publishing the news in newsletters and posting it on communication boards, Longuet recommends.

While MD Anderson does not require the CHAA and CHAM certifications for a position in patient access, they are listed as "preferred." The center will implement a new skills program this fall. Patient access specialists have the opportunity to receive up to $1,200 per year for passing the CHAA, performing highly on their evaluation, continuing their customer service training, and passing institution-specific competency assessments.

It's not enough for individuals to demonstrate good patient access skills. They also need to set achievable evaluation goals, participate in performance improvement projects, mentor other patient access staff, and enhance their customer service skills through continuing education.

"Our patient access staff are reacting positively to the opportunity for additional recognition and pay," says Longuet. "We have 62 staff members sitting for the CHAA."

Certification is an integral part of the new skills program, both at the national level and at the institution level. "The CHAA ensures that a patient access specialist has the knowledge to successfully process patients, from the point of first contact through final services being rendered," says Longuet.

To demonstrate that the institution values continuing education, MD Anderson Cancer Center covers the cost of the certification for all staff who wish to achieve this status. "The CHAM ensures that our managers have the managerial skills and patient access knowledge to lead our teams successfully," says Longuet. (**See story, page 91, on avoiding pitfalls with career ladders.**)

Don't forget re-certification

"Re-certification is just as important as initially passing the CHAA or CHAM," says Longuet. "Once an individual has earned their certification, they must show initiative to keep it. This is a valued trait that employers look for."

Maintaining certification does not require any additional testing. "It merely requires someone to continue growing with their profession by showing continuing education activities," says Longuet.

By completing the education requirements needed to recertify, an individual shows he or she is actively involved in the industry. "There is a continued commitment to keep up with current trends, setting this apart from a job and making it a career choice," says Longuet.

Losing their CHAA or CHAM status means that staff no longer receive the additional skills pay. "It is our duty as patient access directors to ensure training opportunities are available for staff to meet the recertification requirements," says Longuet.

Longuet recommends researching activities that count toward community education, such as those set up through NAHAM. "Many of these are free or inexpensive for an institution," says Longuet. "And, any cost that an institution spends for continuing education will come back to the institution in terms of enhanced revenue cycle processes, resulting in maximum reimbursements."

[For more information, contact: Connie Longuet, CHAM, Patient Access Services, The University of Texas MD Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, TX 77030. E-mail: clonguet@mdanderson.org.] ■

Maximize benefits of access career ladders

Be clear about criteria

Career ladders can be an excellent way to improve retention in your patient access department. However, there are some pitfalls to avoid. "Career ladders must be current and relevant to the job," says **Holly Hiryak**, MNSc, RN, CHAM, director of hospital admissions and access services at University Hospital of Arkansas in Little Rock. "There may be complacency if [employees] are not goal-driven with measurable roles and responsibilities."

Some career ladders focus on accuracy and speed without taking individual behavior into account, says Hiryak. She recommends the following:

- Promote staff based on objective criteria, such as accuracy, quality, attendance, and productivity.
- Be clear about responsibilities that are not measurable, such as customer service.

Otherwise, staff may see patients as customers, but not other departments. To address this, Hiryak recommends explaining to staff the difference between "on-stage" and "off-stage" behaviors.

- Align with human resources to ensure that the program meets facility requirements.

For instance, the organization may have monetary restrictions, or limitations on bonuses or incentive pay.

- Define the reasons for developing a career ladder.

Your goal is to establish clarity for all involved, from development to implementation. "A career ladder provides an opportunity to develop individuals from novice to expert," says Hiryak. "There is a minimum level of achievement expected. No one can opt to remain at the novice level."

The career ladder should not be based on years of experience, adds Hiryak. "Just because you have been in a role for 10 years does not necessarily mean you are an expert," she says. "This must be demonstrated through behaviors and annual competencies."

Courtney M. Higdon, director of enterprise patient access services at UK HealthCare in Lexington (KY), says the organization has focused "very intently" in recent months on redesigning patient access to clinical services.

"We are a large academic medical center with a two-hospital system and a significant multidisciplinary specialty group practice," says Higdon. "Just last fall, we launched our patient access center, which schedules patient appointments and pre-registers their visits. Three factors drove us to pursue this model."

Those were: low patient satisfaction with access, inability to effectively facilitate appointments for referring physicians, and structural inefficiencies and turnover in scheduling and registration personnel.

"At the patient access center we have created a career progression opportunity for personnel in these positions," says Higdon. "We have begun to develop a significant training and on-boarding program, the Access Academy, as well."

The career progression program serves to offer new patient access personnel a true opportunity to advance within the organization, preparing them for a number of different health care career tracks.

"The Access Academy will serve to bring patient access staff into the organization with a foundational knowledge and perspective on the entire enterprise," says Higdon. "It will serve to provide continuous professional development and growth opportunities."

The goal is to have staff understand the value of their role in the patient experience and the revenue cycle. "Having an appreciation of one's value within an organization fosters a stronger commitment and individual performance," says Higdon.

[For more information, contact: Courtney M. Higdon, Director, Enterprise Patient Access Services, UK HealthCare, University of Kentucky, 800 Rose Street, Lexington, KY 40536. Phone: (859) 257-6780. E-mail: Courtney.Higdon@uky.edu; Holly Hiryak, MNSc, RN, CHAM, Director, Hospital Admissions/Access Services, University Hospital of Arkansas, 4301 W. Markham, Little Rock, AR 72205. Phone: (501) 686-8170. Fax: (501) 603-1243. E-mail: HiryakHollyM@uams.edu.] ■

Put a stop to chronic complaints from staff

Ask them for solutions

At one time or another, every patient access manager has come across a staff person who habitually complains, spreading negativity to other employees. "A constantly complaining staff member can cause the entire department to feel burdened by their complaints," says **Melinda Clark**, RN, CHAM, director of admitting at University of Kansas Hospital in Kansas City. "It can affect teamwork negatively. The staff member will often be avoided by their co-workers."

Complaints also can diminish patient satisfaction for the entire department, if patients and fam-

ily members hear the staff member's gripes.

Clark encourages staff who have complaints to come up with solutions. "I empower them to implement those solutions, if they are reasonable," she adds.

One way of doing this is to involve the complaining staff member in meetings and groups. "They can provide input and have a say in what happens in our department," says Clark. "Encourage the employee to participate in process improvement initiatives. Give them a voice in department changes."

However, if constant negative comments are affecting patients, families, or internal customers, Clark says "it would be a disciplinary situation. Also, if they do not respond to coaching and requests to participate in the department initiatives, and they continue to complain excessively, it would warrant a disciplinary situation."

Boost retention

Vicki Lyons, patient access manager at Baptist Hospital East in Louisville, KY, acknowledges that for patient access departments, retention and good morale "is always a challenge."

"A lot of times, patient access is a starter area for employees to get their foot in the door," says Lyons. "I always say it takes a good year to learn all aspects of registration and be efficient. It is not a position that we want to constantly keep rotating employees through."

From the staff member's perspective, in fact, there may be a lot to complain about. "Patient access is where everything starts. Because of that, a lot of times when information is entered incorrectly or a patient complains about an issue, it is thought to have happened when the patient first came in," says Lyons.

Since new employees have a lot to learn, it often seems to them that they are being picked on when they first start in the department, explains Lyons.

To keep complaints to a minimum, the department uses several approaches. There are levels that an employee can move up to once he or she has the required knowledge and meets certain other criteria. "This gives the employee something to work toward," says Lyons.

"WOW" cards can be filled out by colleagues or customers, which let employees know they have done an exceptional job. And perhaps most importantly, staff always receive the benefit of the doubt.

When staff make errors such as entering an incorrect doctor's name or giving out incorrect information, Lyons always asks for the employee's input first. "I never insinuate that they are at fault. I always want to hear what they have to say," says Lyons.

Sometimes the situation is completely different than it seemed at first glance. Or, staff may have a reasonable explanation for their mistake, such as having taken information from a run sheet because the patient was unconscious.

Whatever the reason for the mistake, Lyons always puts the focus on the patient. She explains why it is important that the correct information is entered, or gives staff pointers on how to address certain issues that may arise with a patient.

"I also try to pat them on the back for a job well done," says Lyons. "It's always nice to hear good comments and not just the complaints." If she sees a good note that was made on a patient's account, staff get an e-mail complimenting them on it.

For instance, something on an account may look incorrect, but there is a detailed explanation about why the information was entered the way it was. It could be a note about why no Medicare is on file for a patient over 65.

"I always tell the staff that the note screen is their best friend when it comes to a registration," says Lyons. "Any registration that is not the norm should always have a note explaining why the information was not obtained, or why the registration was registered the way it was."

[For more information, contact: Melinda Clark, RN, CHAM, Director of Admitting, The University of Kansas Hospital, 3901 Rainbow Boulevard, Kansas City, KS 66160-7220. Phone: (913) 588-5876. E-mail: MCLARK5@kumc.edu; Vicki Lyons, Patient Access Manager, Baptist Hospital East, 4000 Kresge Way, Louisville, KY 40207. Phone: (502) 897-8159. E-mail: Vlyons@BHSI.com.] ■

Can you reach patients by cell, text, e-mail?

Many are requesting it

In the past, when they needed contact information for patients, registrars typically obtained an address and home telephone number and their job was done. But these days, many patients would rather be reached on their cell phone or via e-mail or text messages.

Patient access leaders at Advocate Illinois Masonic Medical Center in Chicago are in the process of implementing an automated system to allow patients

to designate if they want an appointment reminder for outpatient diagnostic testing.

"Many reminder messaging systems provide only one type of reminder for the patient," says **Michael F. Sciarabba**, MPH, CHAM, the hospital's director of patient access services. "We thought the ability for the patient to decide their preference was crucial to improving patient satisfaction."

The system allows patients to decide what kind of reminder they want. They can choose to be contacted by phone, voicemail, text, or e-mail.

"Although we are in the implementation phase, we have already instructed our staff to work to obtain e-mail addresses," says Sciarabba. "Many patients expect us to ask, and readily provide their information."

Others want an explanation as to how this information will be used. In general, staff respond by stating, "We are working to improve communications with our patients." Patients can be given examples of outpatient appointment reminders, on-line obstetrics pre-registration, on-line account management, and community event reminders.

"Cell phones are the most common form of communication, so we have expanded the ability to have more than one phone number listed," says Sciarabba. "We have changed our script in asking the patient, 'What is the best number to reach you?'"

A growing number of patients — about 50% — at St. Francis Health Center in Topeka, KS, prefer to be reached by cell phone, reports patient access manager **Barb Shields**, CPC, CPC-H, CHAM.

"We have noticed a marked increased in this request during the past year," says Shields. "A growing number of patients are also asking if they can be e-mailed. We get that request about once per week."

Registrars ask patients, "What is the best way to contact you?" Most often, patients give their cell phone number. "We always try the home phone first, then the cell phone if it is listed," says Shields. "We have several patients that prefer cell phone, so we indicate the account as such."

St. Francis is currently looking into the feasibility of contacting patients via e-mail. However, Shields says she doesn't think that e-mails or texts will replace the reminder phone system anytime soon. "The biggest challenge with e-mails and texts is the cost associated, and also, being compliant with HIPAA [the Health Insurance Portability and Accountability Act]," she says.

Katie M. Davis, director of patient financial services at Carolinas Medical Center in Charlotte, NC, says that obtaining valid, current contact information for patients is a key area of focus for her department.

"Having the incorrect information can hamper follow-up calls from physicians and nursing staff," she explains. "Any calls regarding patient satisfaction cannot be made. With an incorrect address, any insurance questions or billing follow-up cannot be completed."

The department is currently collecting cell phone numbers as another method for contacting the patient.

Staff use a script to help patients understand the importance of being able to contact them. The script begins with, "We are committed to your safety and to ensuring that we record your information correctly."

Patients in the ED are told that a correct phone number and address needs to be on file, in case the physician needs to contact them regarding any test results.

"When dealing with the address, we are sure to clarify the apartment or lot number if there is one, the telephone number and area code, and the zip code," says Davis.

[For more information, contact: Katie M. Davis, Director, Patient Financial Services, Carolinas Medical Center, Charlotte, NC. Phone: (704) 512-7181. E-mail: Katie.Davis@carolinashealthcare.org; Michael F. Sciarabba, MPH, CHAM, Director, Patient Access Services, Advocate Illinois Masonic Medical Center, 836 W. Wellington Avenue, Chicago, IL 60657. Phone: (773) 296-5071. E-mail: michael.sciarabba@advocatehealth.com.] ■

Take steps to ward off ID fraud on the front end

Being aggressive pays off

Undocumented individuals may have a single Social Security card and pass it around to several people. In other cases, an electronic medical record may describe a patient of a different age or gender than the person standing before you.

There is no question that patient access staff are seeing many more cases of patients with fraudulent identities. In addition, some patients are asking for help because they are victims of identify fraud.

"More frequently, we are being asked by patients to put an alert on their account because they have been subject to identify fraud," says

Alesha N. Delgiacco, interim manager of inpatient access at Lancaster (PA) General Hospital. "They want to ensure that we are asking anyone who is using their name for photo ID."

Patients at Lancaster General have, in fact, used the names of their identity theft victims — not just on one occasion, but many times. "Due to the frequency of the patient's visits, our team will question, 'Weren't you here last week? You look familiar,'" says Delgiacco.

"We try to deter them from using another's persons ID," says Delgiacco. "I commend my staff on their teamwork and wanting to get it right, as well as the nurses who clue us in to discrepancies in patients' stories."

Get the word out

"We've been dealing with this for over a year, but it seems like it's happening more often now," says **Linda Durst**, medical information services operations manager at OSF Saint Francis Medical Center in Peoria, IL. "We know there is a problem. We see it sometimes once or twice a week."

Identity theft occurs mainly in the ED, and less rarely in the hospital's urgent care center or outpatient testing sites. "We had to update our policy and procedure and make sure everybody was on the same page," says Durst.

The department has taken steps to gain a reputation for being tough against identity fraud. "I think with us being aggressive about it, we are seeing a decrease. So possibly, the word is getting out," says Durst.

Previously, if registration staff thought that identify fraud was occurring, they would tell the patient's nurse. The nurse would attempt to get the correct information, but the first priority is always clinical. "We never wanted to not treat a patient. That was our first concern. Also, we had concerns about violations of EMTALA [the Emergency Medical Treatment and Active Labor Act]."

After the patient was treated, the clinical person at that point would call the police. Under the new policy, however, hospital security staff are called first.

"They come down and try to get the person to own up to who they really are before we call the police. It is just an added step," says Durst. In some cases, seeing a uniformed person makes the patient admit to the identify fraud.

If something doesn't seem quite right to registration staff, they excuse themselves. A different registrar comes in and asks the patient for the same information, such as a Social Security number.

"We ask the questions again to see if they give the same answer," says Durst. "When we start questioning them, sometimes they will say they're going to get their wallet in the car, and they never come back."

In some cases, law enforcement have become involved. "We've actually had one patient bring us back money, because that was part of his deal with the court," says Durst.

If a patient becomes upset, registrars stop questioning that person and contact security. "They know their limits, and know to back off if anybody's riled up," says Durst.

In the ED, the patients committing identify fraud typically aren't critically ill, says Durst. Most are seeking pain medications.

"Staff explain to them that it is very important that we are treating who we think you are. We try to help the patient understand that if you give us the wrong identity, we could do harm to them because it's somebody else's medical record," says Durst. (**See story, page 95, on dangerous implications for patients.**)

Identity fraud is part of orientation and precepting of registrars. Staff use scripts and are encouraged to involve supervisors if they feel at all uncomfortable.

"We really work together on this issue, because it is a little unnerving," says Durst. "We want to be sure that we don't falsely accuse anyone. But we're pretty aggressive on this."

If patients don't want to give their name because they can't pay for the care, they might qualify for federal assistance programs or charity, adds Durst. "We are seeing an increase in self-pay patients, especially in the ED," she says. "We really encourage them to fill out the Sisters Charity within the hospital. If they are eligible, they can get all levels of care with that."

Linda Swanson, registration coordinator at Mercy Medical Center in Oshkosh, WI, says that her hospital has seen "just a few" instances of fraud on the front end, from using a fake name to using another person's identity and insurance.

"This, of course, can have many negative issues for the 'true' patient, from wrong information on their medical files to claims submitted to their insurance," says Swanson. "There may be complete write-offs for patients who are using fake names, who most of the time have no insurance."

In response, the hospital system has developed a policy of asking for picture identification from patients who do not have insurance. "We've found that helps deter patients from using a fake name

and information, at times," says Swanson.

For patients who report having had their identity stolen, staff can put in a pop-up message. Anyone doing a registration on future visits will then check for identification.

"When identity theft does occur, it takes much investigation and work to clear up, from changing the name on the records for that visit, test results, to holding the billing until things are cleared up," says Swanson.

To guard against identity theft, the patient's and guarantor's Social Security numbers were removed from all registration forms and labels. "We still capture these, but they do not show up on any paperwork," says Swanson. "We also shred confidential paperwork or anything that would have a patient's name or information on it."

Staff also are trained to always keep paperwork turned over whenever a new patient enters their office. "Small items like these do help to deter identity fraud/theft," says Swanson.

[For more information, contact: Alesha N. Delgiacco, Interim Manager: Inpatient Access, Lancaster General Hospital, 555 North Duke Street, Lancaster PA 17604. Phone: (717) 544.4029. E-mail: andelgia@lancastergeneral.org; Linda Durst, Medical Information Services Operations Manager, OSF Saint Francis Medical Center, 530 NE Glen Oak Avenue, Peoria, IL 61637. E-mail: Linda.M.Durst@osfhealthcare.org.] ■

For patients, fraud has dangerous implications

If identity fraud occurs, there are a number of negative repercussions for patient access, but this is also true for patients.

"There are potential financial implications when it comes to reimbursement," says **Alesha N. Delgiacco**, interim manager of inpatient access at Lancaster (PA) General Hospital. "There are serious and very dangerous implications when it comes to electronic medical records, if false names are used."

Access staff use the registration system to flag accounts if they suspect identity theft or insurance fraud. Each time the patient presents, the system sends a pop-up message, which prompts registration personnel to complete an action or ask a question.

"We have the potential to ward off the misuse of someone else's information on the front end, while the patient is still visual," says Delgiacco. "We contact security and get their involvement. Most 'fess up to the truth when confronted."

Therefore, patient access is able to bill correctly and update the "flagged" account. "Our goal is to give every patient the best care possible, despite their ability to pay," says Delgiacco. "Sometimes we are able to figure out the patient's financial needs and assist them with counselors while they are in the hospital."

The hospital's security department now gets involved in potential fraud cases. If fraud is suspected, all information is turned over to security for a follow-up. The legal department also reviews cases for potential follow-up actions.

"When we get a pop-up message, if we are unsuccessful in obtaining the correct answers to the questions, we involve security," says Delgiacco. "Our patient access department places a 'flag' on a record of potential or actual fraud."

Richard Pride, director of access management at University of Mississippi Medical Center in Jackson, says that the patient access department is the first line of defense for detecting fraud.

"Unless you use some electronic software that helps prevent fraud, you struggle to be accurate in detecting it," says Pride. "We are left with the questions we ask during the registration process as signals of an issue or recognizing that the driver's license or form of identity is fake."

Both come down to a gut feeling of the employee, which may or may not be correct, adds Pride. "Many more patients are arriving at the hospital that are out of jobs, which can lead to more attempts of fraud," says Pride.

The department's policy states that the employee is to immediately report any suspected case of fraud to his or her supervisor. The supervisor does a brief investigation to gather some facts, no lon-

COMING IN FUTURE MONTHS

- Dramatically reduce clinically related denials
- Completely revamp processes for self-pay
- Put a stop to inaccurate registration data
- Verify contact information electronically

ger than 30 minutes to an hour.

"The supervisor gathers the original information that made the staff suspicious that there could be an issue," says Pride. "It could be talking to a parent, friend, or the registrar to find out what triggered this patient as a concern.

"If we have any thoughts that it may be fraud, we are required to notify compliance and campus police," says Pride. "I believe it is important to gather this information while the patient is still present, although it does not usually occur that way. Usually, it is a parent or phone call that triggers that there is an issue."

For example, patients will call when they receive a bill and say that the bill does not belong to them. "That is enough to start an investigation," says Pride.

The hospital is in the process of purchasing a new electronic health record. "The plan is to include a software piece to detect fraud," says Pride. "We are leaning toward thumbprint recognition at this time, but a decision is still a few months away."

If the fraud goes unrecognized, Pride says that patient can potentially go all the way through the system on incorrect information. "This can affect many areas of treatment, including blood typing, allergies, and denials, just to name three," he says.

The department has had cases of a patient using a sibling's account. The blood bank goes to type and match the blood and it does not match what is in the system. "The blood bank must stop and we must go back and confront the patient," says Pride. "This causes a delay in treatment. But the consequences to the patient if [the wrong blood type] is given can be deadly."

[For more information, contact: Richard Pride, Director, Access Management, University of Mississippi Medical Center, 2500 North State Street, Jackson, MS 39216. Phone: (601) 815-1650. Fax: (601) 984-4881. E-mail: rpride@umc.edu.] ■

BINDERS AVAILABLE

HOSPITAL ACCESS MANAGEMENT has sturdy plastic binders available if you would like to store back issues of the newsletters. To request a binder, please e-mail *binders@ahcmedia.com*. Please be sure to include the name of the newsletter, the subscriber number and your full address.

If you need copies of past issues or prefer online, searchable access to past issues, you may get that at *http://www.ahcmedia.com/online.html*.

If you have questions or a problem, please call a customer service representative at 1-800-688-2421.