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Revenue: POS collections surge from $100 monthly to $40,000

Hospital administrators challenge access

At St. Joseph East/St. Joseph Jessamine in Lexington, KY, collections in a newly opened women's hospital went from only about $100 in March 2010 to $15,000 a year later, and preadmissions collections, which were just $1,300 monthly, now range from $15,000 to $40,000. Stanford (CA) Hospitals and Clinics expects to collect $1 million more at point-of-service in 2012. *(See story on the changes they made, p. 123.)* In 2010, registrars at West Virginia University Hospitals — East collected 110% more than the previous year and expect to increase it another 10% in 2011. *(See story on how they accomplished this, p. 123.)*

However, most hospitals still collect under 30% of payments at the time of service, primarily because staff can't determine what patients owe, and patients aren't prepared to pay, according to a new study.

Administrators at University Health Care System in Augusta, GA, challenged access to increase point-of-service (POS) collections from fiscal year 2010 by about 8%, says **Julie H. Deason**, CHAA, BSHA, manager of central registration.

"This affects the entire revenue cycle," says Deason. "If an access employee can collect on the front end, it cuts down on costs for the back end to try and collect."

If registrars determine that a self-pay patient actually does have insurance by using a real-time eligibility system, for example, this step reduces work on the back end in patient accounts and collections, says Deason. "By cutting down on these accounts, FTEs have been reduced in the entire revenue

Next month: Best strategies for education and training

Next month's issue of *Hospital Access Management* will be a special issue on education and training. We'll give solutions to keep staff updated on payer and regulatory requirements, strategies for dramatic improvements in customer service, and the best ways for patient access leaders to evaluate the skills of registrars. Don't miss this special issue of *Hospital Access Management*!

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cycle," she says.

The state of Georgia implemented a hospital bed tax that reduces the bottom line by 1.45% and redistributes that money in the local Medicaid programs, which means the hospital is seeing decreased reimbursement, says Deason. "The number one challenge in our organization is the growing number of indigent patients and the economy," she says.

Here are changes that the access department made:

• Access staff call patients scheduled for outpatient procedures before their registration to verify all of their information.

"About 6% of our patients pay over the phone. We are working on increasing that number," says Deason. Because patients don't have to wait to be registered, they simply sign a consent form, get an armband, and go directly to the service area, she says.

• Staff members use a real-time eligibility system to calculate the patient's financial responsibility.

The tool pulls the CPT code from the scheduling system and uses the patient's individual contract to calculate the charges, allowable amount, coinsurance, deductible, and copayment information.

"We are in Phase I of the initiative. We have seen some increase in collections, but mainly a decrease in accounts on the back end in collections," says Deason. While Phase 1 only included outpatient radiology and the emergency department, Phase 2 will include surgeries.

"This is where we will see the largest return on investment," she says. "Currently, we do not call these patients or collect on them because we do not have accurate financial estimations. We expect our POS collections to increase drastically."

New proactive approach

At University of Mississippi Health Care in Clinton, past collection efforts began only after services were provided and the patient received a bill. This process has changed dramatically and now begins when a request for service is received, says **Vidette W. Owens**, MHA, manager of financial counseling.

"Several changes have been made in recent months to increase POS collections," Owens says. First, a comprehensive financial assistance policy was developed to clearly define the organization's payment expectation. "The immediate results of this initiative have been more accurate anticipation of charges,

EXECUTIVE SUMMARY

Patient access departments are being asked to make dramatic changes in point-of-service (POS) collection processes to increase hospital revenues.

• The Women's Hospital at Saint Joseph East collects up to $15,000 a month, up from just $100 a month. Preadmissions collections which were $1,300 monthly at Saint Joseph East/Saint Joseph — Jessamine now range from $15,000 to $40,000. Stanford Hospitals and Clinics expects to collect $1 million more at POS in 2012. West Virginia University Hospitals — East collected 110% more in 2010 than the previous year.

• Contact patients before arrival to take payment. Use an eligibility system to calculate the patient's responsibility. Give patients a printed estimate of their liability after insurance.

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Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**

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Editorial Questions
For questions or comments, call Joy Dickinson at (229) 551-9195.

financial screening, and financial resolution prior to the patient's arrival for service."

A particular area of focus has been the financial counseling unit, which consists of these three teams:

- **Team 1:** Financial counselors who educate patients regarding their obligation, identify other sources of funding, and screen patients for Medicaid or financial assistant eligibility;
- **Team 2:** Health benefits advisors, who contact patients prior to their scheduled visit, who provide an estimate of the cost of the visit, and collect pre-payments if the patients would like to satisfy their obligation prior to arrival;
- **Team 3:** Financial assistance coordinators, who provide estimates for services, collect pre-payments, or establish payment plans.

Owens says that her biggest challenge with POS collection is providing the tools needed for staff to provide an estimate, collect, and process the payment received. "What we are seeing from our efforts are patients who are educated regarding cost of service. They are willing to satisfy that obligation either prior to, or at the point of, service," reports Owens.

POS is "huge focus"

Lisa Johnson, a patient access manager at Saint Joseph East/Saint Joseph — Jessamine in Lexington, KY, says that POS collections are a "huge focus for the patient access departments within our system."

A "real time" eligibility checker tool was implemented, and staff members rely heavily upon a tool that provides estimates and patient responsibility breakdown, Johnson reports. "The effect of the economy has resulted in many patients being unable to pay, or paying very little toward their financial responsibility," she says.

The pre-registration process is vital to POS collections, says Johnson, because it gives an opportunity for this conversation to happen before the patient arrives. "POS collections have really rocketed in the preadmissions department, and we are seeing substantial increases in our OB hospital," she reports.

SOURCES

- **Anna Dapelo-Garcia**, Administrative Director, Patient Access Services, Stanford (CA) Hospital & Clinics. Phone: (650) 723-9292. Fax: (650) 498-6718. E-mail: ADapelogarcia@stanfordmed.org.
- **Julie H. Deason**, CHAA, BSHA, Manager, Central Registration, University Health Care System, Augusta, GA. Phone: (706) 774-2745. Fax: (706) 774-7606. E-mail: JulieDeason@uh.org.
- **Audrey Hodson**, System Director, Patient Access Services, West Virginia University Hospitals—East. Phone: (304) 596-5711. E-mail: ahodson@wvuh-east.org.
- **Lisa Johnson**, Patient Access Manager, St. Joseph East/St. Joseph Jessamine, Lexington, KY. Phone: (859) 967-5881. Fax: (859) 967-5332. E-mail: johnsoli@sjhlex.org.
- **Vidette W. Owens**, MHA, Manager, Financial Counseling, University of Mississippi Health Care, Clinton. Phone: (601) 926-3876. Fax: (601) 926-3533. E-mail: vwowens@umc.edu. ■

Department expects $1 million increase

Anna Dapelo-Garcia, administrative director of patient access services at Stanford (CA) Hospitals and Clinics, anticipates point-of-service (POS) collections will increase by more than $1 million in 2012.

"As a tactic to accelerate cash, we began to focus on increasing POS payments through co-payments, deductibles, and residual/statement collections this past year," Dapelo-Garcia reports.

In addition to increased efforts for collections of co-payments and deductibles, staff collect residual balances at the POS and provide patients with a formal estimate of what their liability will be after all third party payers have settled. "For collections related to expected liability, we are working with an outside vendor to develop a patient liability estimator," says Dapelo-Garcia. "This will be based on our [Charge Description Master], our insurance contracts, and our historical average charges."

Staff members will give patients a printed estimate of what their liability will be after insurance and ask them how they would like to pay it, she explains. "Determining what a patients' cost is for a procedure or test before the fact has always been an exceedingly difficult and time-consuming process," Dapelo-Garcia says. "Being able to provide the patients with a formal estimate has significantly improved POS collections at several hospitals."

POS cash collections shorten the revenue cycle and decrease collection expenses and bad debt, adds Dapelo-Garcia. "Every POS collection has zero A/R days," she says. "If we wait to ask for payment, some of the patients who would have paid at POS may not pay when they are billed." ■

Upfront collections set to increase by 130%

Members of the patient access staff at West Virginia University Hospitals — East collected 110% more in 2010 than the previous year and are hoping to increase that by an additional 10% for 2011, reports **Audrey Hodson**, system director for

patient access services.

"We have a three-year goal of 130% increase in upfront cash collections," explains Hodson. "Once we reach the end of our third year, we will shift our efforts to focus on actual cash collections versus total amount due."

In 2010, upfront collections was included in the department's five annual goals for the first time. "The financial stability of our organization depends on this," says Hodson. "It is a community service for our patients to be made aware of their estimated financial obligation."

More collections on the front-end results in lower write-off dollars going to bad debt on the back-end, she explains. "Numerous changes have been made within patient access to accomplish our cash goals," says Hodson. These steps were taken:

1. Staff members in the pre-service department were given training in verifying insurance benefits, including deductible, co-insurance, or co-pay, and in looking for medical necessity, authorization, and/or pre-certification as needed.

Staff members prepare an estimated financial responsibility for each patient based on scheduled tests and procedures, and they contact the patient prior to the service date to discuss payment options. 'This prepares the patient to pay a deposit or total financial responsibility upon presenting for care," says Hodson. "It also educates the patient on their own insurance coverage and policy limitations."

2. Front-line registration staff members were educated in asking patients for money.

The first step was making registrars aware of the financial impact of bad-debt write-offs that happen in patient accounting. "We provided staff with a process to look up charge amounts for most outpatient services," says Hodson. "They provide a good estimate for total charges at point-of-service and set standard payment amounts such as a $75 deposit for ER visit."

3. Access leaders obtained hospitalwide support.

"The change was that now we would be asking patients to make a payment at the time of service," says Hodson. "We needed total buy-in on this from area physicians, facility administration, and the board of directors."

Patients overwhelmed

Staff contact patients with scheduled procedures before their service and ask walk-in patients to pay a deposit toward services.

"We have set-up a standard guideline for the staff to follow," says Hodson. "We ask for 10% of the total charges, or a flat amount of $25, $50, or $100, depending on the services the patient is receiving."

Registrars are seeing many patients with recurring medical conditions who are "simply overwhelmed" with medical bills from hospitals, clinics, pharmacies, and physicians, reports Hodson. "We offer a charity financial assistance program to alleviate some of the financial burden for this patient population," she says.

Patients are faced with difficult decisions and anxiety about the anticipated results of tests and procedures, says Hodson. "Now, the hospital is asking them to pay for their services in real-time. They have already paid their doctor and now have to come-up with the funds to pay the hospital, too," she says.

Members of the patient access staff offer financial counseling and many payment options. "We have even made agreements with many physician offices that we will follow their payment arrangements," says Hodson. "If the patient agrees to pay the physician 30% of their portion, we will accept the same 30% deposit toward their total amount due for the hospital." ■

Simple ways registrars can satisfy patients

Make a connection

Patients at the Women's Hospital of Greensboro (NC) might have multiple visits during their pregnancies, which allows registrars to create an ongoing relationship, says **Donald B. Conrad**, patient access supervisor.

"Patients and families have long memories when it comes to remembering staff who treated them well and those who did not," says Conrad. "The initial impressions we give the patient last for years afterward."

Conrad says that access staff must "be very sensitive" to the reason the patient is presenting to the hospital. "We have asked staff to 'engage' the patient," he says. "By 'engaging,' we mean finding something in common with the patient, going beyond normal expectations and making them feel that they are very special."

Empathy for the patient and the families creates a special bond that affect the rest of their visits, says Conrad. Each week, he reviews the actual written patient surveys to determine trends and put the individual patient's experience into context. "This

EXECUTIVE SUMMARY

To improve satisfaction, have registrars find something in common with the patient, make eye contact, and address him or her by name. Use these approaches:

- Give patients your full attention.
- Validate the patient's feelings.
- Convey patient preferences to the oncoming shift.

determines which areas need to applauded and which need extra attention," says Conrad. "We have found invaluable advice from our patients in their written words."

Listen closely

Patients are understandably dissatisfied if they aren't given the full attention of staff, says **Patti Burchett**, director of registration and central scheduling at Bronson Methodist Hospital in Kalamazoo, MI. "If staff are talking with other co-workers, or permitted to text and e-mail in patient areas, they aren't able to listen closely to the patient and answer their questions," she says.

In general, says Burchett, it's very easy for staff to "become lost in the 'busyness' and business of patient access."

Registrars must be diligent about patient throughput, comply with rules and regulations, accurately obtain and enter patient data, and make sure all forms are signed and co-pays are paid. "Those things all must be done," says Burchett. "What makes the difference is doing those tasks within a culture of patient and family-centered care."

Burchett emphasizes the importance of non-verbal communication techniques, such as smiling and making eye contact. "We always address patients by their names and give them our full attention," she says. "Staff diffuse high emotions with scripting such as, 'Sounds like it has been a rough experience,' or 'I can see we haven't met your needs.'"

Staff begin conversations with "Good morning" or "Good afternoon," and end with, "Is there anything else I can do you?" "Conversations don't need to be long," says Burchett. "A few words that identify and validate the patient's feelings are all that are necessary."

If registrars know a patient likes to sit in a recliner and be left alone with periodic checks or likes to engage in conversation, he or she passes on that information to the next shift, says **Betty Bopst**, director of patient access at Mercy Medical Center in Baltimore, MD. Bopst cautions her staff to avoid an "assembly line" impression.

"Registrars think in terms of speed. It takes a special kind of person to have the ability to keep the work going, while making time for a little chit-chat with a patient," she says.

SOURCES

- **Betty Bopst**, Director of Patient Access, Mercy Medical Center, Baltimore, MD. Phone: (410) 332-9390. E-mail: bbopst@mdmercy.com.
- **Patti Burchett**, Director, Registration and Central Scheduling, Bronson Methodist Hospital, Kalamazoo, MI. Phone: (269) 341-6370. Fax: (269) 341.6648. E-mail: burchetp@bronsonhg.org.
- **Donald B. Conrad**, Supervisor, Patient Access, The Women's Hospital of Greensboro, NC. Phone: (336) 832-6619. Fax: (336) 832-4114. E-mail: don.conrad@conehealth.com. ■

Identify common goals: It's to your advantage

Goal is mutual respect

After a registrar immediately blamed a clinic because she wasn't able to verify a patient's demographics, **Nicole Marsoobian**, supervisor of preregistration at Tufts Medical Center in Boston, sent her to the clinic for an hour.

The registrar saw only two coordinators at the front desk checking patients in and out of a high-volume clinic. At one point, with six patients waiting to be checked in and two waiting to check out, a coordinator was pulled away to interpret for a patient, which left one coordinator to perform all functions.

"It has changed the registrar's outlook. She learned that there are many reasons why processes may fall through the cracks," says Marsoobian.

Too often, patient access and other departments work against each other, which causes claims denials, patient complaints, and scheduling problems, says **Stacy Calvaruso**, CHAM, assistant vice president of patient management at Ochsner Health System in New Orleans. "In many facilities, I have seen a lack of communication between access individuals and clinical care areas," Calvaruso reports. "This causes a general misalignment of priorities. It affects the organization's overall success."

Calvaruso holds shared meetings with clinical areas on compliance-related issues, add-on services, and schedule reconciliations. She adds that the patient access leaders team must consistently reinforce the main goal of any healthcare organization: serving the patients. "The biggest hurdle that many leaders face

EXECUTIVE SUMMARY

Patient access areas might be at odds with other departments, which can cause complaints and claims denials. To identify common goals:
- Hold shared meetings.
- Have staff observe other departments for an hour.
- Provide information that can benefit other departments.

will be how to get their team members to respect the value that each area brings to the other," Calvaruso says.

Many common goals

In fact, patient access shares many common goals with other departments, including quality assurance, customer service, patient satisfaction, and payment collection, Marsoobian says.

"Lack of communication between patient access and other departments creates a direct impact on revenue cycle processes," she adds.

There is a duplication of efforts due to resources not being shared and overlapping responsibilities, resulting in miscommunication and a lot of rework, she explains. "In addition, statistical data is ineffective and cannot deliver the accountability that drives performance. Not only is the organization affected, but the patient experience suffers," says Marsoobian. She recommends taking these steps:

• Create a workgroup, with department leaders meeting periodically.

"During these meetings, leaders can talk through ways to better manage common goals that work for everyone," says Marsoobian, adding that areas of focus might include patient complaints about long wait times or departments failing to verify key data fields at scheduling and check-in.

• Ensure that information flows between departments.

Marsoobian advises, "Always provide information from your department that can benefit other departments on a regular basis," such as a list of non-contracted and contracted insurance payers for departments, assignment lists of employees and their direct extensions, and contact information of financial coordinators.

• Encourage registrars to meet staff in other departments face-to-face.

Marsoobian sets up a specific time period for her staff to sit in other areas of the hospital, to obtain a better understanding of what different departments do. "During this hour, they can observe a 'day in the life of the department,'" she says.

SOURCE

Nicole Marsoobian, Supervisor, Pre-Registration, Tufts Medical Center, Boston. E-mail: nmarsoobian@tuftsmedicalcenter.org. ■

Keep patients happy when delays occur

Avoid finger-pointing

During morning surgery rush times, registrars at Indiana University Health North Hospital in Carmel began monitoring the actual time patients were arriving in a database.

"We learned that even though surgery times are staggered, and the patients are told to come in 15 minutes prior to surgery, they were actually arriving closer together," says **Brian Sauders**, manager of patient access services.

The earliest scheduled patients would arrive slightly before the department opened, while the later scheduled patients would arrive well before they were instructed to arrive. "Rather than having evenly staggered arrivals, it was more like a bottleneck," says Sauders. "If 10 patients were scheduled to arrive, we would actually see closer to 20."

Armed with this information, Sauders set out to base patient access staffing on actual volumes. "We have limited FTEs, so we couldn't just add more people," says Sauders. "Instead, we utilize registration team members from different areas of the hospital. If the ED isn't really busy, we'll pull somebody to come help."

Although ED registrars aren't necessarily familiar with the specifics of the surgical registration process, they keep things moving by checking in patients or keeping them continually informed.

Monitoring arrival times helps patient access to work more closely with other service lines, such as imaging, adds Sauders. If a patient was scheduled to come 15 minutes early for a 2:30 CT scan but instead arrives right at 2:30, for example, the patient might complain to imaging that he or she had to wait despite being right on time. "In that case, the imaging location can apologize to the patient, but when imaging comes back to us, we can let them know the patient was actually 15 minutes late," says Sauders. "That allows us to work better internally as a team."

Keep patients in loop

"We don't have a lot of patients waiting an

EXECUTIVE SUMMARY

If patients are waiting, be clear about the reason for the delay, and avoid blaming other departments. To improve satisfaction:

- Refer to the patient's physician by name.
- Monitor actual arrival times.
- Call patients at home to apologize.

extended amount of time, but if we do for some reason, we keep them in the loop," says Sauders. "It may be that we are chasing down an order for the patient." If that's the case, patient access staff members take these steps:

• They make a point of using the patient's physician's name when talking to the waiting patient, such as stating, "We spoke to Dr. Johnson."

"That helps them to understand that we are truly doing what we say we are," Sauders says, since patients feel more comfortable knowing that access staff actually spoke to their physician.

• They identify specific stumbling blocks to a frustrated patient, such as the fact that the order was mistakenly faxed to a different location.

"In that case, we tell them that we're going to find the order. But we also let them know that we cannot complete what we have to do without that order," Sauders says.

Staff members explain that not completing the registration, and consequently the service, without the order helps to meet safety standards and is in the patient's best interest. "When explained in that manner to the patient, they have a higher level of assurance that we are here to provide the best service to them," says Sauders.

• They resist the temptation to point fingers.

"One thing we do *not* do is start bashing the other service line," Sauders says, adding that patient access staff instead convey to patients that they work closely with their physician and the department the patient is going to.

• If a patient is adamant that his or her physician faxed something that wasn't received by registrars, they don't argue about it.

Instead, the patient is reassured that patient access staff work closely with the patient's physician, with comments such as, "They are really good about getting us those orders. Let us just check and follow up with them," says Sauders.

"We never place blame," says Sauders. "We can't put ourselves in a light that the patient is in bad hands or that anyone is incompetent. We want to assure them that they are in the right place."

The department's wait time logs indicate that 98% of patients are seen within 10 minutes, and 92% of those are seen within five minutes. "A check-in person out front is our air traffic controller," says Sauders. "We are constantly guiding our patients. We know who has the patient now and which patient needs to be next."

If a patient does complain about a wait, patient access staff call him or her at home to apologize. "People are often surprised by that," says Sauders. "They generally compliment the staff. This is a great way to get feedback, because we don't have any formal surveys for patient access."

SOURCE

• **Brian Sauders**, Manager, Patient Access Services, Indiana University Health North Hospital, Carmel. Phone: (317) 688-3032. E-mail: bsauders@iuhealth.org. ■

Access wrongly blamed for clinical mistakes?

Confront the problem

Has your access staff been wrongly blamed for mistakes, delays, or other problems related to clinical areas? To avoid this problem, patient access must "link themselves with clinical departments and establish a relationship — a tight one," says **Barbara Snodgrass**, patient access manager at Legacy Mount Hood Medical Center in Gresham, OR. Snodgrass gives these recommendations:

• Meet clinical managers in person.

Snodgrass and her colleagues routinely attend staff meetings in clinical areas, which gives them the opportunity to offer feedback from the access perspective.

"You're meeting with people who you may have only talked to on the phone before," she says. "You've truly made progress when a director of surgery asks you to attend more meetings to get input on what you are seeing on the front end."

This sharing might be as simple as reporting that you're seeing registrations get bogged down at a certain time of day because patient volumes have increased, which then brings up the question of whether staffing needs have changed. "Access staff may lack understanding about what clinical areas do," says Snodgrass. "They are more effective on the front end with this knowledge."

She attends ED charge nurse meetings along with her supervisor and ED registration lead, as the ED

EXECUTIVE SUMMARY

Patient access staff might be unfairly blamed for mistakes related to clinical areas, and good communication is the key to avoiding this. To improve relationships:

- Attend staff meetings in clinical areas.
- Explain what access does.
- Share your data.

medical director wants input from everyone who services the department. "If you leave somebody out, like patient transport, patient access, or housekeeping, something won't work," Snodgrass says. "If patient access is included, our patients win."

• Explain why access staff members' actions are helpful to clinical staff.

"Patient access staff tend to be very detailed people, while nursing teams want to focus on the individual," says Snodgrass. "There is sometimes a breakdown in understanding the importance of the money coming in."

Educate clinical areas that patients have a right to understand what their bill is going to be and that this understanding can result in better overall patient satisfaction in their area, Snodgrass recommends. "Otherwise, the patient is coming in worried about money because they are in the dark about what they're going to owe," she says. "If things don't go well upfront, the patient is going to come to them frustrated."

Likewise, if the patient encounters delays at registration related to clinical areas, the visit isn't likely to go well when the patient is seen finally. "You've already set the tone of the visit, and now you are trying to recover from it," says Snodgrass. "When your clinical partners realize that, there is more of a sense of collaboration."

Share your data with clinical areas.

Clinical managers might not realize that your patient access areas monitor wait times, for example, which is valuable information for them.

"They don't always understand that a lot of information we are gathering is helpful for long-term strategic planning," Snodgrass says. "Show them why specific data collection is helpful to a clinical outcome of a hospital." *(See related story, right, about informing patients about delays.)*

SOURCE

• **Barbara Snodgrass**, Patient Access Manager, Legacy Mount Hood Medical Center, Gresham, OR. Phone: (503) 413-4367. Fax: (503) 413-2428. E-mail: BSnodgra@lhs.org. ■

Delays? Be clear who is responsible

If an admitted patient is impatiently waiting for a bed to become available, and all he or she sees is access staff, it's easy to come to the wrong conclusion about who is really responsible for the delay.

"When we are the ones talking to them, there is a sense that patient access 'owns' those beds," says **Barbara Snodgrass**, patient access manager at Legacy Mount Hood Medical Center in Gresham, OR.

In this situation, Snodgrass says to be clear about what the obstacles are and what is being done about them, instead of simply saying, "We're working on it." Instead, she recommends telling the patient, "Our nursing supervisor is aware of this issue and is working on this for you. I will report back to you in 10 minutes."

"Now, the patient has something he or she can understand," says Snodgrass. "Don't assume a patient realizes all of the complications involved with getting a room. They may think that you just find a room and send them up there."

Likewise, an emergency department (ED) patient might believe wrongly that members of the registration staff are the ones responsible for his or her long wait. "Patients don't understand that the ED is not a clinic, where you see a person arrive after you and you go in before them," she says. "That's something that gets people really irate."

ED registration staff might need to inform patients that the front end staff members aren't responsible for the order patients are seen, says Snodgrass. Problems occur when patients receive mixed messages, she says. "If a triage nurse comes out and blames access, that is a sending a very bad message to the patient," Snodgrass says. ■

More payers require info on clinical review

Denials are the result

Payers are frequently requiring additional clinical information from the provider or medical staff as to the medical necessity for a procedure or surgery, says **Nan Olivieri**, a supervisor at the Financial Clearance Center at Hennepin County Medical Center in Minneapolis.

Clinical staff might not always be familiar with insurance terminology, due to the use of different terminology such as notifications versus authorizations, she explains. "Clinical staff do not always have administrative time and are not always prepared to respond to some of the insurance inquiries," says Olivieri, adding that financial clearance staff diligently work to complete all inpatient notifications and authorizations within the pre-established timeframes required by different insurance companies.

The best strategy is to have a centralized clearing center for all inpatient authorizations and notifications, with staff fully trained to administer and document pertinent information in a timely manner, says Olivieri.

To avoid future denials, the denial team reports back to departments when trends are identified specific to that area, such as a lack of authorization, says **Lori Nix**, the hospital's claims manager of revenue cycle management. "Once they're aware of denials, most clinical areas are very interested in what they can do going forward to prevent these denials from occurring," she says.

For example, technicians were informed about authorization denials related to radiology services. "We do this not to point out errors, but to educate them on what the payers are actually looking for in order to pay the claim," says Nix. *(See related stories on avoiding denials based on clinical necessity, below, and how a multidisciplinary team reduced denials, p. 130.)*

SOURCES

• **Lori Nix**, Manager, Claims Revenue Cycle Management, Hennepin County Medical Center, Minneapolis. Phone: (612) 873-6078. Fax: (612) 630-8294. E-mail: Lorraine.Nix@hcmed.org.
• **Brian A. Todd**, CHAM, Manager, Patient Access Staff Development and Training, Lourdes Health System, Camden, NJ. Phone: (856) 824-3125. E-mail: toddb@lourdesnet.org. ■

Payers zeroing in on clinical necessity

Strong verification process needed

Brian A. Todd, CHAM, manager of patient access staff development and training at Lourdes Health System in Camden, NJ, is seeing additional restrictions coming from companies that are doing clinical necessity checking.

"We're seeing this mostly in the radiology modality, but it can encompass other departments as well, such as outpatient cardiac testing," says Todd.

Some of the clinical necessity checking companies are not using "groupers," in which a group of similar procedures is covered under the umbrella of one authorization, says Todd, so the importance of obtaining the correct procedure requested at the time of scheduling has become crucial.

Previously, a CT scan of the abdomen with contrast or without contrast would have been considered in the same group, but this situation is no longer the case. "We're now finding we must be specific, even down to the use of contrast," says Todd. "The clinical necessity checking companies are zoning in on specifics."

To minimize costs and mitigate their insurance risk, payers are seeking to ensure their members are getting the tests they deem necessary, says Todd. "They are, in a sense, guiding the referring physicians' hands into a protocol of what studies they feel should and should not be administered, based on the diagnosis and supporting health factors," he says.

This change means that patient access needs to work more closely with provider's offices, says Todd, who adds that the best method he's found is to build relationships with insurance verification staff at physician offices. "That collaboration helps them to realize that they are in the same boat, with a common goal of ultimately getting the patient serviced," he says.

Denials might occur due to the absence of a referral or authorization prior to testing being done or out-of-network limitations, says Todd. "These can be combated with a strong insurance verification process, as close to the point of scheduling the procedure as possible," he says.

If a claim is denied because additional procedures are done while the patient already is in the department, add-on procedures that manage to bypass the established process, or a patient's pre-existing conditions, these denials are more difficult to manage, acknowledges Todd. This is that point at which the cooperation of the ancillary department and the physician's office becomes essential, he explains. "The gamble here is that the add-on testing will be

EXECUTIVE SUMMARY

Payers are increasingly requiring clinical review for authorizations, including specific information as to the medical necessity of a procedure. To avoid denials:
- Report trends to clinical departments.
- Educate clinical staff on what payers are looking for.
- Work closely with insurance verification staff at provider's offices.

approved at some point by the ones doing the clinical necessity checking," Todd says. "You want to make sure the process to get the authorization is started *prior* to the actual service being performed." ■

Avoid denials: Get it right at the start

When an interdisciplinary team including patient access, insurance verification, and radiology personnel was formed to reduce claims denials, "realizing where denials are coming from was definitely our first step," reports **Brian A. Todd**, CHAM, manager of patient access staff development and training at Lourdes Health System in Camden, NJ.

Here are changes that were made:

• Communication was improved between insurance verification and the clinical departments.

First, members of the patient access staff call the physician's office to obtain a new order for the additional study, which is immediately faxed up to the insurance verification personnel.

"This catches those procedures that must be done for the patient but were not included in the initial procedure schedules," says Todd. "If applicable, an authorization is then sought."

• Patient-friendly scripting is used, in the event that a patient cannot have the additional services performed due to insurance requirements.

Access staff state, "There is an additional study that we and your physician would like to have you have done. However, it does need to be scheduled with our scheduling department prior to us performing it. They will make every effort to get you scheduled for this additional study on a date and time that is convenient for you."

"This type of 'patient-first' verbiage ensures that the patient doesn't feel like some monetary factor is standing in the way of their testing," says Todd. "The patient knows their healthcare is important to us, and we are protecting the financial viability of the organization."

• The importance of "getting it right from the start" is emphasized.

"Our schedulers are kept up to date on all procedure changes that would affect how they would process and offer an appointment to a patient," says Todd.

Schedulers work with a "cheat sheet" so they can reference the insurance requirements at the point of scheduling. If an authorization is required, for instance, it wouldn't be in the patient's best interest to schedule a procedure for the following day when it can take up to five business days to obtain the proper certification. "This concern is expressed to the patient as well, so everybody is on the same page," Todd says. "For patients where there are no insurance requirements, though, we seek to get the patient an appointment as early as the very next available day."

• Staff make sure the doctor, the organization and the insurance company are "on the same page" with the description of the testing requested.

"With us not necessarily being CPT code experts, the description on the patient's script may not necessarily match the description in the CPT book," says Todd. "Ultimately, the insurance companies are referring to the test by that CPT number, so our effort is spent on making sure everything is 'matchy-matchy.'" ■

Put a stop to common, costly claims denials

Many involve communication breakdowns

Keeping up with all the new payer requirements "is getting overwhelming," reports **Margie Mukite**, director of patient access at Advocate Condell Medical Center in Libertyville, IL. Here are some trends the department is seeing:

• Denials due to incorrect coding.

Registrars might provide the correct code to the payer, but the payer mistakenly puts through a different one, says Mukite. Registrars take extra care to specify the procedure codes, but they also document the time of the call and the individual's name in case the claim is later denied, she says.

"We use that supportive documentation, as to the type of procedure, to overturn those denials," says Mukite. "With proper documentation on the account, we have overturned pretty much all of them."

• Denials based on the patient's status.

Payers often deny claims for admitted patients who initially were called in as outpatient or same-day admits, and vice versa, says Mukite. "When we convert the patient to inpatient status, we have the verifiers notify the payer of the admission," she says. "That has to occur within

the timeframe of the patient's stay in the hospital."

Whenever a patient's status is changed, verification staff members are alerted electronically so they can notify the correct payer, Mukite reports.

• Denials based on additional procedures received by the patient.

An authorization might be obtained for a CT of the abdomen, but during the procedure, the provider decides to add a CT of the pelvis. "If there is no communication with the payer, we are not going to get paid for that," Mukite says.

Mukite and other patient access leaders review specific denied claims with unit managers of clinical areas. "This has been successful, because the technicians actually get to see the dollar amount of the lost revenue," she says. "They then have to come up with a strategic plan for how they are going to improve the process."

Denials due to the payer's claim that a procedure should have done on an outpatient basis.

These denials are happening even when the patient clearly met the hospital's criteria for inpatient status, says Mukite, "but the payer is saying that it doesn't meet *their* criteria. We reach out to our physicians to help us overturn the denial."

Even if providers give additional clinical information, though, Mukite has seen many claims unsuccessfully appealed due to lack of documentation. "The challenge is that we have to refer to what is documented in the chart," she says. "Since the patient is already discharged, there is not really much we can do."

If the patient's chart indicates he or she met criteria for observation or outpatient status, that documentation stands even if the decision was made later to admit the patient, says Mukite. "We can't go back and change the order to say the patient is being admitted," she says. "We have to catch that *before* the patient is discharged, so we can properly obtain authorization."

Case management now make an extra effort to identify discrepancies regarding the patient's status, such as a patient classified as an outpatient, but the order states that the patient will be admitted within 24 hours, says Mukite. "They alert us to make the changes, and it goes into the verifier's queue," she says.

• Denials for patients who come in as self-pay, who have insurance that is later uncovered by financial advocates.

"This was an area of broken-down communication," says Mukite. "The information was being added to the system, but it wasn't getting to the next step."

The verifiers are now alerted so they can contact the payer to notify them of the patient's admission when the patient is still in the hospital, she explains.

• Denials involving a miscoding of payers.

About 20% of denials are due to this problem, says Mukite, who adds that patients often present Medicare cards without revealing that they have additional insurance.

"Every facility I know has issues with this. The associates have to be very sharp," she says. "Patients don't understand this and require a lot of education to explain how this works."

Because payers are administered by different companies, registrars might mistakenly select the incorrect payer instead of the main carrier, adds Mukite.

"If the registrar incorrectly codes a patient as Medicare, and a month later it's denied because the patient actually had an HMO, now you have to go through the whole appeals process," Mukite says. "It's going to get denied, because you didn't call it in on time."

EXECUTIVE SUMMARY

Claims denials might occur due to incorrect coding, changes in the patient's status, additional procedures performed, and other unmet payer requirements. To avoid denials:

- Review specific denials with clinical managers.
- Identify discrepancies regarding the patient's status.
- Educate registrars on how to select the correct payer.

SOURCE

Margie Mukite, Director of Patient Access, Advocate Condell Medical Center, Libertyville, IL. Phone: (847) 990-6070. E-mail: margie.mukite@advocatehealth.com. ■

COMING IN FUTURE MONTHS

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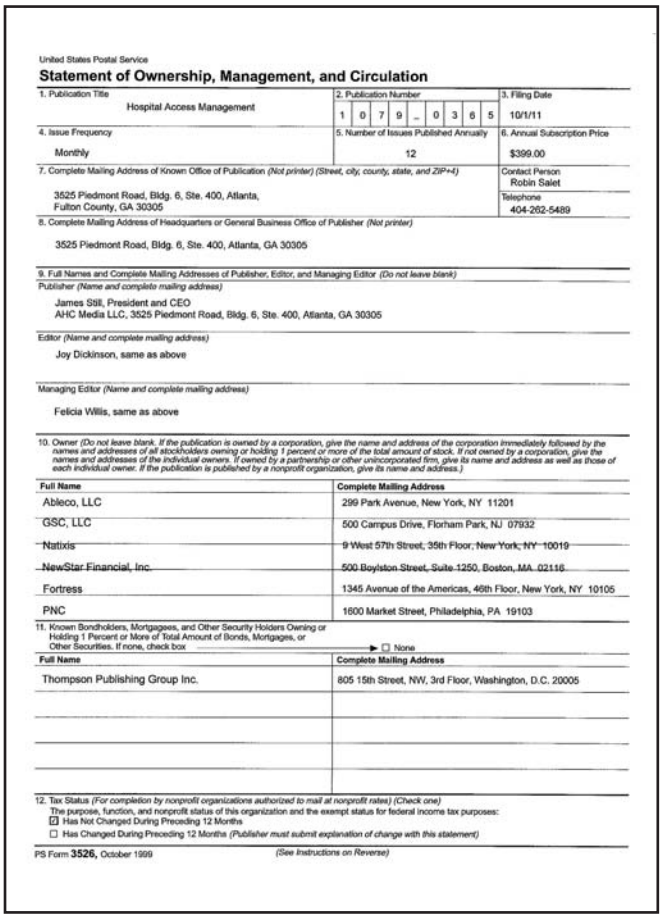

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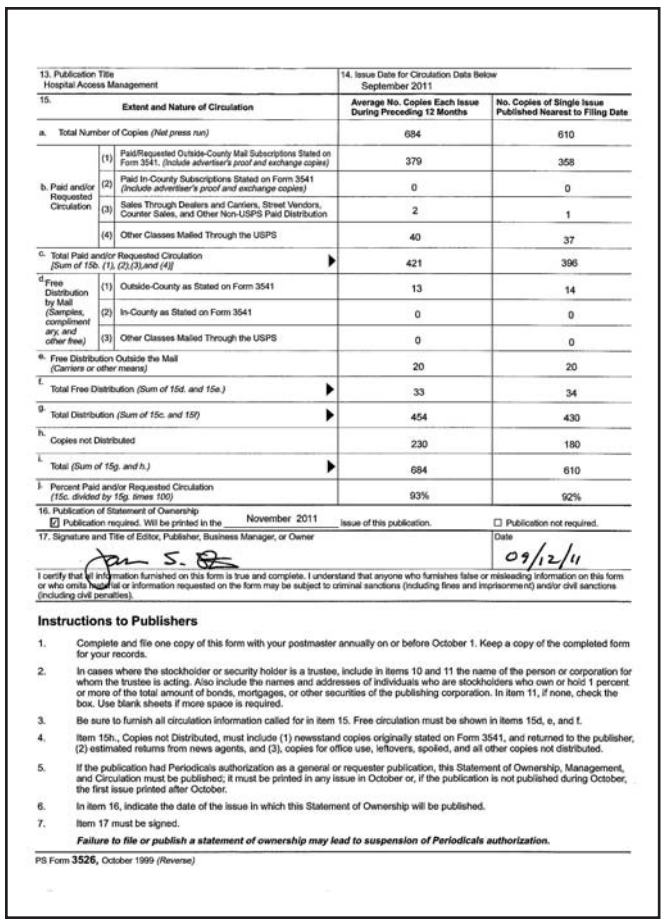

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HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Will your patients have more access to laboratory results? It's proposed

New rule will enable patients to bypass physicians

As hospital compliance officers prepare for a proposed increase in patient access to medical records' information, another proposed rule increases access to laboratory results. Comments on the laboratory proposed rule must be received by Nov. 14. *(For more information, see "Proposed rule allows patients to see record access details,"* HIPAA Regulatory Alert, *August 2011, p. 1)*

The latest proposed rule related to medical records allows patients to access test result reports directly from labs as opposed to receiving the information from their physicians. Under existing Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations, a laboratory may release patient test results directly to the patient only if the ordering provider authorizes the laboratory to do so at the time the test is ordered, or state law allows for it. Although the HIPAA Privacy Rule allows patients access to their medical records, the privacy rule defers to CLIA regulations in the case of laboratory results, explains **Jane Pine Wood,** Esq., an attorney at McDonald Hopkins, in Dennis, MA. This difference means that in the 26 states without laws authorizing direct disclosure of test results to patients or the 13 states that expressly prohibit it, patients do not have direct access to their laboratory results. *(For more information about how state laboratory access laws differ, see resource box, p. 3.)*

> ***"A significant issue that must be addressed is the fact that the role of the physician's interpretation and consultation with the patient will be subverted when patients get the results directly from the lab."***

Bill Wilson, administrative director of the laboratory at Stamford (CT) Hospital, says, "Patients should be able to get their test results directly from the lab. The Internet makes it easy for people to understand what their cholesterol results or blood sugar levels mean." Laboratories in Connecticut can release reports directly to the patient with the ordering provider's approval. "We ask for the patient's identification, verify that it is their information, and give them a printed copy of the results when they request one," he adds.

Although ac-

EXECUTIVE SUMMARY

Increased patient access to personal health information is a key focus of proposed HIPAA rules affecting hospitals. Hospital laboratory managers and compliance officers have until Nov. 14 to comment on the latest proposed rule that will give patients the right to receive laboratory test results directly from the laboratory rather then only through the physician.

- The most significant concern is the inability for patients to understand the implications of many test results without the consultative advice of a physician.
- Hospital labs must determine protocols to ensure proper identification of person requesting information as well as how to distribute results to patients.
- Because Medicare and most insurance will not cover the cost of providing additional reports, hospitals must determine if and how they will charge patients for the expense.

cess to lab results can help patients ask more specific questions of their physicians and make informed choices about lifestyle changes, the challenge that needs to be addressed is related to the more complex tests that may be ordered, says Wilson. "Without a physician's interpretation and explanation of the results, the patient won't know what to do with them," he explains.

Rodney W. Forsman, president of the Clinical Laboratory Management Association in Chicago and assistant professor emeritus of laboratory medicine and pathology at Mayo Clinic in Rochester, MN, says, "A significant issue that must be addressed is the fact that the role of the physician's interpretation and consultation with the patient will be subverted when patients get the results directly from the lab."

It will be important for labs to develop a cover letter for all results given directly to patients that instructs them to call their physician to discuss the meaning of the test results, Forsman suggests. "Lab personnel will need to make it clear that they cannot explain the meaning of results," he adds. "Other issues that must be addressed include the method of delivering results to patients, how to verify the patient's identity when making a request, and how to cover costs associated with providing results directly to patients. Some hospitals already give patients access to lab results through a secure web site, so it will not be an issue for them."

> ***"The best place to get information on what test results mean is the physician."***

Other hospitals will need to develop a protocol that addresses whether to provide print copies of reports that are mailed to the home address or electronic copies of reports that are transmitted through e-mail, he points out.

Wood says, "Some reports may be as many as 30 pages, and even if the report is short, staff time is needed to find the report, print it, and mail it. Hospital billing departments will not want to handle charges of $5 or $10 for producing and mailing the report, and insurance will not cover the cost, so hospitals will have to decide if they are going to provide the service free."

At Stamford Hospital, reports to the physicians are automatically sent to a secure fax line identified by the physician, so no staff time is involved to produce and send the report, Wilson says. "We can set up the system to generate a report for the patient, but at this time, the only way to send it electronically is to a fax," he says. "We don't use e-mail for reports because we don't have a way to be sure the transmission is secure."

Concerns about e-mailing reports should not be an issue, says Wood. "If the patient instructs a lab to send the report by e-mail and provides the e-mail address, it does not violate any privacy regulations," she says. Some states may require that the lab encrypt the message that is sent, but there is no requirement that the receiver take any security measures, Wood adds.

While hospital lab managers and compliance officers should be thinking about protocols that might need to be developed, be aware that comments on the proposed rule are being accepted until Nov. 14, she points out. There may be changes to the proposed rule that might affect actual procedures the lab must take, Wood adds.

Forsman says, "Hospitals have always been required to provide the patient's medical record when requested, and although CLIA regulations prohibited the release of lab results to patients, many hospitals either do not take time to delete lab reports in the record or are unaware that they are supposed to do so. So patients have been receiving lab reports in their medical records." The change that the proposed rule represents is that it supersedes state regulations and existing CLIA regulations that prevent release of reports directly to patients, he explains.

Overall, the proposed rule is a good step, says Forsman. "Information can help patients make positive changes in their lifestyle to improve their cholesterol or blood sugar levels, and a lab test can reinforce the benefits of their efforts," he says. "It can also help patients prepare to ask questions of their physicians."

The most important task of all labs will be to find a way to keep the physician in the loop, admits Forsman. "The best place to get infor-

mation on what test results mean is the physician," he points out. "We may need to develop procedures to notify physicians when their patients ask for results to be given directly to them, so they can follow up, because unfortunately, not all patients will go back to the physician if they think they have their answers."

SOURCES/RESOURCES

• **Rodney Forsman**, President, Clinical Laboratory Management Association, 401 N. Michigan Ave., Suite 2200, Chicago, IL 60611. Telephone: (312) 321-5111. Fax: (312) 673-6927. E-mail: forsman
rodney@mayo.edu.
• **Bill Wilson**, Administrative Director of Laboratory, Stamford Hospital, 30 Shelburne Road, Stamford, CT 06904. Telephone: (203) 276-1000. E-mail: wwilson@stamhealth.org.
• **Jane Pine Wood**, Esq., McDonald Hopkins, 956 Main St., Dennis, MA 02638. Telephone: (508) 385-5227. Fax: (508) 385-4355. E-mail: jwood@mcdonaldhopkins.com.

• To see a copy of the proposed rule and to see information on how to submit comments, go to www.gpo.gov/fdsys. On the right-side navigational bar under "Featured Collections," select "Federal Register." Then select "2011" and choose "September" and September 14." Scroll down to "Health and Human Services." Under "Proposed Rules" select "CLIA Program and HIPAA Privacy Rule; Patients' Access to Test Reports Pages 56712 - 56724 [FR DOC # 2011-23525]" Comments about the proposed rule must be submitted by Nov. 14, 2011.

• To access a free copy of "Electronic release of clinical laboratory results: A review of state and federal policies" go to www.chcf.org. Under "Browse" and under "Topics," select "Health IT." On the left side of the page, under "Health IT," select "PHRs and Privacy." Scroll down to ""Electronic Release of Clinical Laboratory Results: A Review of State and Federal Policy." ■

HHS reports complaints and breaches to Congress

Data breaches impact almost 8 million people

More than 57,000 complaints of Privacy Rule violations were received by the Health and Human Services' (HHS) Office for Civil Rights (OCR) between April 2003 and December 2010. More than 250 large data breaches, defined as those involving the protected health information of more than 500 individuals, occurred in 2009 and 2010.

These are just a few of the statistics reported to Congress by HHS as mandated by the Health Information Technology for Economic and Clinical Health (HITECH) Act. More than 19,000 of the Privacy Rule complaints were investigated, with no violation found in 34% of the cases. Of the 800 complaints about Security Rule violations received, nearly half of the 290 complaints investigated were not found to be violations.

The most common compliance issues with the Privacy Rule that the OCR investigated were the following, in order of frequency:

• impermissible uses and disclosures of personal health information (PHI);
• lack of safeguards of PHI;
• denial of individuals' access to their PHI;
• uses or disclosures of more than the minimum necessary PHI;
• inability of individuals to file complaints with covered entities. The most common areas for which entities failed to demonstrate adequate policies and procedures or safeguards, as required under the HIPAA Security Rule, include the following, listed by frequency:

— response and reporting of security incidents;
— security awareness and training;
— access controls;
— information access management;
— workstation security.

A separate report on data breaches in 2009 and 2010 showed that covered entities notified a total of 7.8 million people that their protected health information (PHI) was compromised in a data breach. The most common cause of data breaches in both years covered by the OCR report was theft of paper records or electronic media containing patient information. Other top causes of breaches included unauthorized access, use or disclosure of protected patient information, and human error.

In addition to the large breaches, covered entities reported more than 30,500 smaller breaches to HHS in 2009 and 2010. The OCR report indicated that most of those breaches affected just one individual and were caused by misdirected communications, such as mistakenly mailing or faxing clinical or claims data or test results to the wrong person. *(Editor's note: To see a copy of the full reports presented to Congress, go to www.hhs.gov/ocr/privacy. Under the "Reports to Congress" section on the right navigational bar, choose "HITECH Act Reports to Congress, 9/1/11.")* ■

Study says e-mail is source of data leaks

Unencrypted mobile devices contribute

E-mail practices and mobile e-mail cause the most concern for data protection and regulatory compliance, according to the 830 individuals whose responses were included in a study conducted by the Ponemon Institute and Zix Corp., an e-mail encryption service.

When examining everyday e-mail practices, the study found:

- The majority of respondents strongly agree or agree that the use of e-mail by employees is one of the main sources of data leakage in their organizations.
- 70% of respondents are concerned about the loss of information via e-mail on mobile devices.
- Based on survey results, respondents believe employee behavior continues to place organizations at risk.
- Nearly 70% believe employees ignore policies about e-mailing unencrypted sensitive or confidential documents through insecure channels.
- More than 60% believe employees mistakenly send unencrypted confidential information to other recipient(s) outside the workplace.
- More than 60% believe employees send unencrypted confidential information through insecure e-mail channels, such as personal web-based e-mail.

As more business is conducted outside the office, mobile security has gained considerable attention as a potential threat to data protection and compliance. The study revealed 70% of respondents are concerned with data loss via mobile e-mail. As a result of this concern and the complexity of e-mail encryption on mobile devices, less than one-third of respondents have ever opened an encrypted e-mail on a mobile device.

To see a copy of the full report go to survey.zixcorp.com/downloads/ZixCorpPonemonE-mailEncryptionSurveyReport.pdf. ■

Leon Rodriguez to head up OCR

Leon Rodriguez, the new leader of the government's HIPAA privacy and security enforcer, last served as chief of staff and deputy assistant attorney general for the Department of Justice Civil Rights Division.

"Leon Rodriguez brings a strong record of integrity, leadership, and judgment with his outstanding expertise as a state and federal prosecutor," said HHS Secretary Kathleen Sebelius. "He has devoted his career to ensuring that individuals have access to healthcare, including children and families, the elderly, and people with disabilities. He will also spearhead the department's continued work to ensure greater consumer confidence through strong and effective enforcement of the privacy and security of protected health information."

Rodriguez' background includes serving as the county attorney for Montgomery County, MD, as a shareholder in the Health Law Department of Ober, Kaler, Grimes & Shriver, and was the first assistant U.S. attorney, serving in Pittsburgh, PA, assigned to the prosecution of healthcare fraud cases. ■

Timeline widget for HIPAA 5010

Interactive tool keeps you on track

Beginning Jan. 1, 2012, providers must use the new HIPAA 5010 transaction standards to conduct certain administrative transactions such as claims, remittance, eligibility and others, but not all providers are ready for the transition to new standards, and that lack of preparedness could affect transition to ICD-10 as well.

A free timeline widget to help hospitals stay on track for transition to the new standards is available on the Centers for Medicare and Medicaid Services web site. The interactive tool gives healthcare providers a plan to implement HIPAA Version 5010 as well as ICD-10. To download the widget, go to www.cms.gov/ICD10. On the homepage, in the first sentence of the "Welcome," click on "timelines." This selection will take you to page with the timeline tools and instructions on how to download and use them. ■