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AHC Media

Are collections less than they could be? Training is probably the answer

Staff unaware hospital was 'writing off millions'

When upfront collections first became a focus several years ago at Portland, OR-based Legacy Health's six hospitals, "we started with the basics," says **Lindsay Hayward,** director of patient access and health information management.

Staff members were given scripting to use when asking for copays, along with a list of standard deposits to collect for each type of service. "All of that was working pretty well. But last year, we decided to take things to the next level," says Hayward. "We're 80% above our baseline from when we first started tracking upfront collections."

Hayward attributes the department's dramatic increase in collections to training, setting goals, and implementing price estimator software. Here are changes that were made involving training, as part of Legacy Health's new focus on collections:

• Staff members were told the dollar amount being written off in patient balances for their service area.

"We told staff that the hospitals are losing money we could be collecting," says Hayward. "We were writing off millions, and staff were shocked by the numbers." In addition, Hayward learned that staff assumed that it didn't make any difference if the balances were collected on the back end, so she made them aware of the costs involved.

• Staff members were instructed to ask patients "How would you like to

EXECUTIVE SUMMARY

Training can fill gaps in lost collection opportunities for patient access areas by making staff more knowledgeable about the revenue cycle and more comfortable asking for payment.

- Tell staff the amount of patient balances written off by service area.
- Explain that there is a cost to collecting.
- Show dollar amounts collected by individual employees.
- Set minimum standards for low performers.

pay?" instead of "Would you like to pay this now?"

"Some of our staff had been here for so long that they were used to telling patients, 'You can pay this today, or we can just bill you,'" says Hayward. "They eventually were able to get comfortable asking questions in a different way. We did see our numbers start to jump up after that."

• Amounts collected are posted.

All patient access staff can keep track of the totals collected each month by individuals, service lines, and the overall hospital.

"They can see how much their peers are collecting," says Hayward. "I was hesitant about doing this at first, but it has made staff competitive. They are motivated to be one of the top collectors."

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Aggressive goal

Outside of physician office and ED settings, most patient access staff at Edward Hospital and Health Services in Naperville, IL, weren't accustomed to asking patients for payment at the point of service, says **Orlando Melendez**, director of central scheduling and patient access.

"Therefore, the focus of our training was on communicating the payment message to the patient," he says. "We have a very aggressive goal to increase our point-of-service collections."

The patient access management team trained groups of two to four registrars at a time. "This was done in order to stress the importance of the initiative, as well as to get a sense of any staff anxiety related to asking for payment," says Melendez.

Registrars are required to indicate whether payments collected are part of the point-of-service payment initiative, so a report can be run showing the total dollars collected as part of the initiative.

"This initiative is fairly new for us, so it is too early to tell to what degree the training will increase point-of-service collections," says Melendez. "However, we are off to a good start. More staff are actively asking for payment now."

Incentives not enough

Currently, Bronson Methodist Hospital in Kalamazoo, MI is meeting only about 50% of its collection goals, reports **Patti Burchett**, CHAM, director of patient access.

"Goals were established based on 2 to 3% of net patient revenues for each area," says Burchett. "Our expectation is that our education plan will allow us to fully achieve our targets."

The patient access department trainer provides additional systems training to identify collection information and does role-playing with various patient interactions involving collections. This ongoing training already is helping staff feel more comfortable with requesting payment while maintaining positive patient experiences, says Burchett.

"Similar training will be provided to pre-registration staff. It will ultimately serve to better educate patients," she says. "We will follow our model for improvement of 'Plan, Do, Check, Act,' and re-measure for success."

Bronson offers incentives via an employee benefit called GainShare, notes Burchett, "so we know monetary incentives are not enough alone to meet our

goals."

Results for this payout are tracked by area on a monthly scorecard that is posted on the patient access department web page. "This current system provides an easy way for us to determine the educational impact before and after training," says Burchett. *(See related stories on setting minimum collection standards, below, and using a top collector to train ED registrars, below right.)*

SOURCES

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Struggling collectors may need to try harder

Minimum standards are key

While a small group of registrars at Legacy Health in Portland, OR, were effective collectors, and most were trying their hardest, about one-third weren't making much of an effort to collect anything at all.

"Some were collecting just two copays a month. This group was really bringing down our overall collections," says **Lindsay Hayward**, director of patient access and health information management. "Our big focus now is getting our lowest level performers up to at least an acceptable level."

Patient access leaders set a minimum monthly collection standard for each group of staff, based on the hospital's payer mix and the registration area they work in. For example, in an ED where many self-pay and Medicaid patients are seen, the monthly minimum is 20 copays, compared with 100 copays required for registrars who work in the imaging area.

After minimum standards were set, low performers found they simply had to try harder to collect, according to Hayward. "If staff aren't meeting the goal, we give them additional training. We ask them why they are struggling," she says.

After several employees stated that they felt uncomfortable asking for money since they weren't certain of the amount to collect, Hayward created a "cheat sheet" listing copays, coinsurances, and standard deposits. *[The form used to determine a patient's payment amount is included with the online version of this month's* Hospital Access Management. *For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

The preregistration team and onsite patient access staff also use a price estimation tool for surgeries and procedures, which increased collections about 20%, she adds. "They can now explain the whole picture to the patient and speak to all the different pieces of insurance," she says.

Reluctant collectors were surprised to see that patients actually appreciated being informed of their out-of-pocket responsibility, and some can be offered financial assistance before their surgery or procedure, says Hayward.

"Staff realized that patients really want to know upfront, instead of owing $2,000 on the back end and having no clue about it," she says.

Top performer to train ED registrars

Collections increased 140%

Since copayments first were collected in Cambridge (MA) Health Alliance's three emergency departments (EDs) in October 2008, collections have increased 140%, totaling $173,000 in fiscal year 2009 to an expected $416,000 in fiscal year 2012.

Richard Hollis, Cambridge Health Alliance's director of admitting and registration, attributes this increase to ongoing training provided to registrars and setting monthly collection goals for each ED, based on volume. One of the EDs rarely meets its collection goal, but patient access leaders came up with a novel solution.

"We are going to have our highest collector at our highest collecting campus, who consistently does a wonderful job, do a training for the staff and talk about why she is so successful," he says.

The top collector also will observe the other staff, evaluate them, and offer suggestions, as staff might be more likely to respond to suggestions from one of their peers who does the same job as them, says Hollis. The idea is to have registrars see that the ability to

collect involves more than just following a script, he explains.

"From the moment this employee goes into the room, she makes the patient feel comfortable. Then she gets to the question of, 'How would you like to pay your copay today?'" he says. "We have other people who use the same language, but if they haven't set the patient at ease, the patient may be less forthcoming." Here are other changes that have increased ED collections:

• Managers regularly observe interactions between patients and registration staff.

Although collections had increased significantly by 2011, totaling $306,000, the actual goal for that year was $400,000, notes Hollis. Staff had never collected ED copays before 2008, and many were doing so halfheartedly, he explains.

"We did more training, with more of a focus on manager observation of staff, to try to bring the numbers up," Hollis says. "That was successful."

Managers realized that many times, registrars weren't following the script for collecting copays and instead were asking open-ended questions that gave patients the choice of whether to pay.

In response, says Hollis, "we made sure staff understood that it's actually an advantage to the patient to take care of it right then, to avoid getting statements and future collections going forward."

• Hollis makes a point of emphasizing the collection role when interviewing applicants for the department.

"We make it clear that it's a primary function of their job. Right from the beginning, we are setting this expectation," he says. "They know going in that it's a top priority."

• Spreadsheets show how individuals measure up against their peers.

Some registrars were surprised to learn that they were falling far behind their colleagues, "and we have had a number of staff who have made successful efforts to improve their collections," says Hollis. ■

Cover training needs by adding e-learning

No travel costs involved

Previously, it took some patient access employees over an hour to travel up to 40 miles to a training site for required education at St. Luke's University Health Network in Allentown, PA. Now, employees can take some of the training right from home or at their current facility.

"If we can do some training by e-learning training modules, that saves us time and money. It allows us to focus our education resources on auditing and quality assurance," says **Sandy Sarson**, manager of the outpatient registration and admission service group at St. Luke's University Hospital at Bethlehem.

With an education staff of only three full-time employees, the network is challenged to keep more than 500 employees who perform registration at five inpatient facilities and multiple outpatient facilities up to date, as well as educate new hires, Sarson says. "We had limited resources, and we needed to think out of the box. The thought came to us, 'People do so much online these days,'" she says. "Many of the people we hire are students, and they are very computer literate."

The department began to develop an e-learning module to cut down on the amount of classroom training needed for new hires and existing staff. "This allows employees to learn at their own pace, instead of having to travel to a centralized location," she says. "If we need to do refresher training or remedial training, this keeps us from having to take the employee away from the worksite."

E-learning reduces educators' training time by 16 to 32 hours per month per educator, she estimates. "Current employees are able to review competencies and always have resources available to do all aspects of their position," she says. "This results in higher registration accuracy and performance."

ROI showed savings

Before developing an e-learning module, patient access leaders were required to research a return on investment (ROI) to show how much would be saved.

"We were able to demonstrate that education-related travel costs would be decreased by 50% and supply costs decreased by approximately $1,500 per year due to the elimination of printing and copying of

EXECUTIVE SUMMARY

E-learning modules saved the patient access department $1,500 a year in printing and copying costs and 50% of education-related travel costs at St. Luke's University Health Network. To implement e-learning effectively:

- Allow staff to do training during downtime.
- Identify information needed for specific registration areas.
- Perform audits to compare e-learning with classroom training.

materials," says Sarson.

In addition, there are fewer added hours and overtime for managers to cover shifts during training sessions. "We don't have all those slots filled all the time, so to pull somebody off their regular shift to attend training created a hardship for other people," she explains. "Now, staff are able to complete the training during their downtime onsite."

E -learning is much more convenient for employees who work different shifts because they can take the training whenever they are available, but one pitfall is the lack of someone to answer questions, says **Amy Kirkland**, CHAA, patient access team leader at Palmetto Health Richland in Columbia, SC.

"If someone is in the process of training and has a question, they don't have an instructor available to ask," she says. "They would need to email or call to get an answer." *(See related story, below, on the types of training best suited to e-learning.)*

SOURCES

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Some access info not good for e-learning

Classroom training sometimes necessary

When patient access leaders had to select a subject for the first e-learning module developed at St. Luke's University Health Network in Allentown, PA, they chose computer downtime procedures.

"You don't have them very often, but when you do have them, it's difficult to be sure everyone does things consistently at all the different entities," explains **Joyce Sourbeck**, RN, associate vice president for patient business operations.

Some patient access training topics are well-suited for e-learning, but some types of training clearly aren't, she explains. "With screen flows and entering data, you want to have some direct oversight so someone is available to show what they are doing wrong or help them do it more efficiently," says Sourbeck.

For this reason, training involving accuracy of certain data entry fields, such as insurances, will still be classroom-based at St. Luke's. "That is one module we would not want to do with e-learning, since the precision is so critical," she says. "We want to give a lot of explanation to the trainees about why certain data fields are needed."

On the other hand, Sourbeck says completion of the Medicare as Secondary Payer form makes an excellent e-learning module, because staff can be given multiple choices for which they would select as the patient's primary insurance.

Audits will be done

In the future, new patient access hires at St. Luke's University Health Network will have three days of training onsite and two days remotely through e-modules.

"We will do audits to see whether or not those aspects of registration have higher or lower error rates than before the e-learning," says Sourbeck.

E-learning allows current registrars at St. Luke's to complete yearly competencies and refreshers and allows managers to track their progress. Sourbeck adds that e-learning helps provide staff in various registration areas with the specialized training they need, such as an e-module on the Emergency Medical Treatment and Labor Act (EMTALA) given only to emergency department registrars.

"If you are registering patients for physical therapy, you don't need to spend a lot of time training with people in outpatient registration areas," she explains. "Everyone has different needs." ■

Revamp process for admission notification

Denials down to 0.08% from .68%

If a patient is admitted on a holiday or after normal business hours and registrars are unable to notify the payer until the next business day, the claim could be denied for late notification, warns **Jeanette Foulk**, director of patient access at Methodist Charlton Medical Center in Dallas.

"Our 2012 fiscal year denial rate due to authorizations/notification denials is currently at 0.08%, down from .68% in fiscal year 2010. This is a significant amount of money," she says. These steps are taken by patient access staff to ensure timely notification of admissions:

1. Every day, a registration representative runs a census from the hospital's registration system.

"This logs all of the previous day admissions and the insurances that were listed at time of registration," says Foulk.

EXECUTIVE SUMMARY

Claims will be denied if payer notification requirements aren't met when a patient is admitted, and more payers are requiring same-day notification. Denials due to authorizations or notifications decreased from .68% to 0.08% at Methodist Charlton Medical Center. These changes were made:

- Financial counselors note completion of accounts.
- Same-day admission reports are run throughout the day.
- Staff ask family members for insurance information of ED patients.

2. The reports and demographic sheets for those patients are separated and delivered to financial counselors who handle that insurance carrier.

"We routinely have high volumes. This makes it unrealistic for the registration rep to also try to obtain an authorization at point of registration," Foulk explains. "Each financial counselor will work the report, noting completion of each patient account."

3. Throughout the day, the financial counselor runs a same-day admission report for payers requiring same-day notification.

"We have seen a major increase in our Medicaid HMOs — which is a significant portion of our patient population — requiring same-day notification, along with several commercial payers," reports Foulk.

The same-day report was added because the department was seeing a surge in denials for same-day admissions due to lack of notification, says Foulk. The report is "essentially an hour-by-hour census," she says.

For patients admitted from the emergency department, staff often have trouble obtaining accurate insurance information at the time of admission, which means the patient's coverage can't be verified as active until later on, says Foulk.

"We may rely on a family member to provide us what is needed, which may not be within 24 hours," she says. *(See related story on new authorization requirements for procedures, above right.)*

SOURCES

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Multiple authorizations for single procedures

While many payers required authorization for injectable procedures for some time, they're now adding a new requirement.

"We are now receiving denials for failing to obtain authorization for the medication in those injections. This is something we had not seen previously," reports Jeanette Foulk, director of patient access at Methodist Charlton Medical Center in Dallas.

Currently, patient access staff are seeing authorization requirements for chemotherapy injections that weren't required previously, which leads to high-dollar denials, says Foulk.

"We are now informing the referring physician's office to request a medication authorization code when obtaining the authorization for those procedures," she says. ■

Get clinical info in hands of payers

Resolve communication breakdowns

Payers are asking for much more clinical information before giving authorizations for services, reports **Margie Mukite**, director of patient access at Advocate Condell Medical Center in Libertyville, IL.

When patients are admitted, have surgery or high-dollar diagnostic tests such as magnetic resonance imaging, CT scans, nuclear medicine perfusion scanning, positron emission tomography (PET) scans, or chemotherapy infusions, payers want to know the patient's medical history, including prior treatment plans and clear documentation as to why the medical services are required, says Mukite.

"Payers are requesting CPT and ICD-9 codes," she says. "Aside from the clinical information, payers also are requesting office notes from the past 12 months, and health and physical history."

Payers are asking for CPT codes, diagnosis codes, and clinical information to support the medical necessity of the patient's scheduled services, says **Sharon Mumgaard**, insurance verification coordinator at St. Elizabeth Regional Medical Center in Lincoln, NE. "This information is required to pre-certify mostly high-tech radiology services and surgeries," she says. "However, we have recognized a rise in insurance

EXECUTIVE SUMMARY

Payers increasingly won't give authorization for services without clinical information, and patient access staff might have difficulty obtaining this information from providers. To avoid denials:
- Communicate in real time with physician office staff.
- Follow through to confirm that the authorization is in place.
- Have offices provide CPT and diagnostic codes at the time of scheduling.

pre-certification requirements for other diagnostic tests such as nuclear medicine and sleep studies."

Push-back from MDs

Because clinical information must be provided by the physician's office, close communication with physicians and office staff becomes important in order to get this information submitted prior to the patient's scheduled visit, says Mukite.

With patient access acting as the "middleman" between payers and physician offices, says Mukite, "ultimately, it comes down to real-time communication between the offices, with follow-through by patient access to confirm that the authorization is in place."

Unfortunately, patient access staff members often encounter "push-back" from staff at physician's offices who don't feel providing clinical information to payers is their responsibility, adds Mukite. "They feel that is the responsibility of the hospital. However, we do not have the patients' clinical information," she says. "Higher-ups should be involved immediately, in order to resolve the communication breakdown."

Financial penalties common

Failure to obtain the required pre-certification almost always results in a financial penalty to the hospital or the patient and, often, the complete denial of the claim, says Mumgaard.

"There are times when the physician's offices do not have the ordering physician's dictation available to them so that they can provide the clinical information needed, especially if the services are ordered for the very near future," she adds.

Mumgaard says that the most helpful change in this process would be to have the physician's offices provide more insurance information and CPT and diagnostic codes at the time of scheduling. However, Mumgaard has found the physician's offices to be resistant to making this change, even though more time might be spent in the long run to coordinate this information.

"All healthcare providers are experiencing the need to do more with less," she says. "A closely monitored pre-certification process is definitely a team effort between the facility and the physician office."

SOURCE

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Pinpoint exactly where service problems lie

You need buy-in of all employees

A patient associate at Glendale (CA) Adventist Medical Center was typically extraordinarily polite when dealing with patients, but at times became uncharacteristically impatient with particular callers.

"We listened in on the calls where we had heard a little more impatience in responses and found out the caller was over 70," says **Cynthia Norman-Bey**, the hospitals' director of patient access services and the PBX (private branch exchange) Call Center.

When Norman-Bey met with the employee to discuss this, he first denied that his tone changed with elderly callers, but then listened to the calls himself. "He admitted that it was difficult for him to interact with elderly callers because they asked a lot of questions," she says. Norman-Bey asked the employee to imagine himself, his mother, father, or grandmother as an elderly patient trying to navigate a big hospital campus.

EXECUTIVE SUMMARY

Even high-performing patient access employees might struggle with particular aspects of customer service. To help them succeed:
- Have staff listen to actual calls where exceptional service was given.
- Set clear expectations.
- Role play using scenarios of demanding patients.

"He seemed to have a better understanding of what was needed to overcome his challenge with elderly callers," she says. "His performance improved quickly. He has maintained high performer status within our department."

Set expectations

Although some patient access staff struggle with providing excellent service to particular types of patients, others give subpar service during peak volumes, says **Pam Kohl**, a patient access manager at St. Joseph's Hospital in Marshfield, WI.

"When there are many patients waiting to be registered, it can be stressful. Just getting the job done is the priority," she says.

To address this, Kohl asks employees to openly discuss the challenges of high patient volumes at department meetings and during employee rounding. "They can learn from each other on how 'patients first' always happens," she says. "When it becomes a natural part of the employee's practice, it will occur every time."

Kohl sets clear expectations for employees to put "patients first" in every interaction, but she says this approach works only if all employees buy in to this approach. "One employee who does not follow the 'patients first' value can sabotage the organization's goals. Patients will be affected negatively," she says. "Those employees who fall short and cannot be coached must be moved out of the organization."

When Kohl discovers a customer service issue with an employee by direct observation, results on patient satisfaction surveys, or patient rounding after discharge, coaching is immediately provided. Patient access management, the Employee Assistance Program, human resources, or the hospital's education department can provide the coaching, says Kohl.

"Clear expectations need to be established," she advises. "Identify the expectation that is not being met, and coach to that end." *(See related story, above right, on improving service in patient access areas.)*

SOURCES

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Bring service up to a higher level

When **Cynthia Norman-Bey**, director of patient access services and the PBX (private branch exchange) Call Center at Glendale Adventist Medical Center, notices an employee's customer service skills are lacking, she pairs him or her with a high performer.

"Some patient associate require a 'watch and learn' method of training. They model their behavior after their mentor's," she explains.

Here are other ways to ensure all employees provide excellent service:

• Use actual calls for role-playing exercises.

Staff listen to examples of exceptional service, with staff assisting beyond what was requested by the patient, ending the call with "thank you for your call, and enjoy your day!" and asking whether all the patient's requests were addressed. When a caller wants an appointment, the patient access associate might ask, "Is there any particular day or time that works better for you?"

"That type of appointment scheduling sets the tone," says Norman-Bey. "The patient feels that they have options, as opposed to patient access services only giving the patient what the system says is available."

Staff also role play based on calls from patients who were demanding or even antagonistic. If a caller angrily says, for example, "You had me on hold for a long time, and I am calling from work," staff apologize first, says Norman-Bey, and say, "I know your time is valuable, and we really appreciate your business."

Next, staff might offer to validate the patient's parking on the day of the appointment and meet them face to face, and again apologize for their wait time on the telephone call made to the department.

"We try to show how our own behavior — apologizing, maintaining a caring tone — is what we can control. But we cannot control the behavior of our callers," says Norman-Bey.

• Look at the number of complaints received in the previous six months.

Jamie Kennedy, a patient access supervisor at Columbus-based Ohio State University East Hospital's ambulatory clinic, considers one person receiving three or more complaints to be "a major issue."

"When we notice this pattern beginning, we discuss it with the staff member. We document the conversation in their personnel file as a verbal warning,"

she says. "In some cases, we send staff to refresher trainings on different topics around customer service."

• Be sure patients don't feel rushed through the process.

'In our busier clinics, our staff move very quickly through the registration process. They can come off a bit non-caring at times," Kennedy says. "They sometimes do not take the time to explain what they are doing."

Kennedy has fielded multiple complaints from patients stating that staff went through the registration process so quickly that they didn't feel they could ask any questions. "We always take those complaints seriously," she says. "We speak to the employees and address any issues that are happening upfront."

• Give each employee a chance to voice concerns regarding co-workers.

"Customer service is not just for patients, but also between team members as well," says Kennedy. ■

Patient's coverage inactive? Say this

Registrars in a position to help

A patient recently registered at Denver-based Porter Adventist Hospital had just lost his job and employer-sponsored insurance, and he was under the mistaken impression that COBRA coverage was automatic.

"I didn't know that was the issue. All I knew is he was showing as a self-pay patient," says patient access representative **Tammy Sammon**. "I explained that I didn't see that he had any insurance at that time."

The man quickly became angry, and Sammon arranged for one of the department's health benefit advisors to meet with him. "He found out that he needed to call COBRA to get his insurance going," she says. "He did have to change some things around so that he would be covered. But he was appreciative that we took the time to figure out his situation."

An insurance eligibility tool can instantly tell registrars if a patient's coverage is valid, but it can just as quickly put them in an awkward position. **Jennifer White**, director of patient access at Cottage Hospital in Woodsville, NH, says, "It can be a difficult conversation when the insurance returns inactive."

Cottage Hospital's registrars take these steps:

• The registrar says to the patient, "The insurance information we processed is coming back inactive. Do you have an updated card?"

• If the insurance is actually inactive, staff assure the patient it won't have any effect on the care he or she receives.

• Staff members discuss other options, including internal charity care, payment plans, and external benefits.

Patients are appreciative of the assistance when resolving issues with coordination of benefits, especially when they didn't realize there was any problem with their coverage, White reports. "We have some state insurances that require patients to make monthly payments contributions to his or her plan," she says. "Life gets busy. Sometimes, a payment is missed or forgotten, which in turns becomes inactive for the time of service."

When this situation happens, staff can give the patient the information so they can make the payment or contact the insurance company to verify that payment was received, White says.

Carole L. Sraver, director of patient access at Washington Adventist Hospital in Takoma Park, MD, says registrars typically get in touch with the patients before they arrive for their procedures or treatments to explain the findings and ask "Have you recently switched insurances?"

Patients might have chosen a different insurance plan through their job and forget that they will receive a new card with a different plan number. "This will result in the system telling us the patient's benefits are inactive," says Sraver. "One of our questions will typically prompt the patient to tell us something they had forgot to mention."

Remain empathetic

Sammon notes that a patient's coverage might be inactive due to non-payment of premiums, a job change or loss, or a waiting period to qualify for Medicaid.

"No matter what the situation is, it is always hard to tell the patient that their insurance currently is showing inactive," she says. "I try to be very empathic and remain very calm when telling them

EXECUTIVE SUMMARY

Patient access staff are put in a difficult position when a patient's insurance returns inactive, but it's also an opportunity to offer help.

- Remain empathetic and calm.
- Assure patients their insurance status won't affect their care.
- Discuss charity care and payment plans.

this."

Sammon first verifies all the information. If everything is showing as correctly entered, she offers the patient the chance to speak to a health benefit advisor to learn about possible options.

"They may qualify for charity, or they may be able to put a small amount down and the set up payment arrangements," says Sammon. "Most of the time, the patients feel that you listened to their side, and the hospital still gets some type of payment."

SOURCES

For more information about inactive insurance benefits, contact:
- **Tammy Sammon**, Patient Access Representative, Porter Adventist Hospital, Denver. Phone: (303) 778-5810.
- **Carole L. Sraver**, Director of Patient Access, Washington Adventist Hospital, Takoma Park, MD. Phone: (301) 891-5185. Fax: (301) 891-5407. Email: csraver@adventisthealthcare.com.
- **Jennifer White**, Director of Patient Access, Cottage Hospital, Woodsville, NH. Phone: (603) 747-9252. Fax: (603) 747-9342. Email: jawhite@cottagehospital.org. ■

Wrong primary payer? Bad info equals denials

Ask the right questions

Registrars might learn more information after asking patients with inactive coverage, "While reviewing your insurance, we are getting notification that you have another primary payer. Do you have any other insurance?"

If the answer is yes, registrars can ask the patients to contact their current insurance carriers to update their information so the claims will process correctly, says **Jennifer White**, director of patient access at Cottage Hospital in Woodsville, NH.

"We provide the number to the patient," says White. "We let them know they will be asked when the other carrier policy was terminated, so they will want to have that information available when they call."

Inactive benefits might be due to patients changing their Medicare coverage to an HMO. **Carole L. Sraver**, director of patient access at Washington Adventist Hospital in Takoma Park, MD, says, "They don't understand that it's not a secondary insurance. It is a replacement to their Medicare."

If the proper information is not available prior to the bill being sent out, or if the patient changed to a Medicare HMO product and authorization was needed, the claim will be denied. "In this instance, the patient is not liable, as the hospital failed to follow proper procedure as laid out by the insurance company," adds Sraver.

Washington Adventist's registrars have access to Medicare eligibility software that tells them if a patient is straight Medicare or has changed to an HMO. "Initially, we had to teach the patient access staff what the system was telling them," says Sraver. "Now that the staff is educated, they are better able to assist in educating the patients to understand their insurance coverage."

Members of the patient access staff at Cottage Hospital see a high volume of Medicare patients, says White. "We work regularly with patients to inform them they need to contact Medicare to resolve any payer order issues, or old liability or workers' compensation information," says White.

When registrars receive the information, they ask the patient if his or her services are related to the liability or workers' compensation information that has returned.

"If it is, we update the account accordingly," says White. "If the information is old or closed, we ask the patient to contact Medicare and update them with the information. We provide the contact numbers to the patients to help move the process along." ■

Training challenge with MSP said `huge'

Avoid expensive pitfalls

Is this patient in a Medicare A bed? Does the patient have Medicare coverage, and if so, what type? Is this patient End Stage Renal Disease (ESRD) or disability entitled? What is the patient's entitlement date? How many lifetime reserve days does this patient have left? Is the patient in their 30-month coordination period for ESRD entitlement?

These are all questions that registrars might have involving Medicare Secondary Payer (MSP) says **Kym Brown**, CHAM, patient access manager at Saint Elizabeth Regional Medical Center in Lincoln, NE.

The department's MSP auditor works closely with Brown to provide training to all registration and preregistration staff on the importance of having a correct MSP at the time of registration.

"The MSP audit is a portion of their audited fields in the registration process," says Brown. "If the registrar has a problem with accuracy, additional coaching and training are implemented. This assists the registrar in meeting our expectations."

EXECUTIVE SUMMARY

Medicare patients often give inaccurate information on their coverage to registrars, which results in claims denials involving Medicare as secondary payer (MSP).

- Collect necessary information for aging unbilled accounts.
- Give monthly feedback on accuracy to registrars.
- Be sure all information is correct on the electronic MSP before it is billed.

The auditor provides feedback monthly to registration staff on their accuracy regarding MSP. "Copies of the audited MSP questionnaires are given back to each registrar," says Brown. "It is a coaching opportunity to help the registrars become experts."

The MSP auditor has mini-training sessions with staff members to familiarize them with the purpose of the MSP questions and to teach them how to form their registration questions to help the patient. "The MSP auditor has taught the registrars the importance of each question and helped the registrars to help the patient answer questions," says Brown. "The importance of getting the right information on the claim is a focus."

Give ongoing training

MSP is "a huge training challenge" for patient access, according to **Pete Kraus**, CHAM, CPAR, FHAM, a business analyst with patient financial services at Emory University Hospital in Atlanta.

"It is a complicated, convoluted set of questions that can challenge even experts," he says. "We must coax the information we need to answer it accurately from patients or family who are likely to understand even less about it, if they are able to answer at all."

Feedback from Medicare audits indicated the need to pay more attention to MSP, as well as the financial impact of claims delays and incorrect reimbursement, says Kraus. There is also extra work required by business office and access staff in after-the-fact research and problem resolution resulting from incorrectly completed MSPs, he says.

Emory's patient access department has designated MSP experts who provide ongoing training on a monthly basis. "Our questionnaire is completed online during the interview process," he explains. "It is edited so the answer to one question prompts the interviewer to the next appropriate question."

However, that system doesn't mean that the answer to the preceding questions were correct or that the interviewer actually went through the questions with the patient. "Because this is such a complicated topic even for CMS to explain, the standing classes are a way to refresh staff memory and review department past MSP performance as well as provide updates," says Kraus.

Here is what the trainers do to educate patient access staff on MSP:

- **They divide the MSP into three categories: age, disability and ESRD, and they concentrate on one category at each training session.**
- **Attendance is mandatory, and classes are comprised of 30 minutes training and 15 minutes of completing a question-and-answer test.**
- **Trainers use real examples of incorrectly completed MSPs.**
- **Remedial instruction is provided on a one-on-one basis.**

"Because of the time and preparation involved, the department is looking at the option of using an online educational service to provide monthly MSP instruction and testing to staff," adds Kraus.

SOURCES

For more information on training involving Medicare as Secondary Payer, contact:

- **Kym Brown**, CHAM, Patient Access Manager, Saint Elizabeth Regional Medical Center, Lincoln, NE. Phone: (402) 219-7316. Fax: (402) 219-7199. Email: Kbrown@stez.org.
- **Pete Kraus**, CHAM, CPAR, FHAM, Business Analyst, Patient Financial Services, Emory University Hospital, Atlanta. Phone: (404) 712-4399. Fax: (404) 712-1316. Email: pete.kraus@emoryhealthcare.org. ■

MSP accuracy must be at 98%

Patients might tell a registrar that they still have a Medicare Advantage plan when they no longer do, that they do not have supplement A & B coverage when they actually do, or that they have Medicare for disability coverage when it is really for end stage renal

COMING IN FUTURE MONTHS

- Proven strategies to collect high-dollar deductibles
- Avoid problems when Medicare patients aren't admitted
- Eliminate common obstacles to ED copay collection
- Use cutting-edge tools to stop patient identity fraud

disease.

"We used to have many challenges with getting accurate information on the claim," says **Kym Brown,** CHAM, patient access manager at Saint Elizabeth Regional Medical Center in Lincoln, NE.

Patients weren't always knowledgeable of what their coverage was, says Brown. "Medicare requires accuracy. When the correct reason for, or the dates of entitlement are not correct, the claim is denied," she says.

A dedicated FTE at Saint Elizabeth Regional now audits Medicare Secondary Payer (MSP) status for all Medicare accounts, using online tools to verify Medicare entitlement. "We were able to justify the FTE because quality and denials management are a priority at our organization," says Brown. "It was immediately cost-effective. Our incomplete claims and denials are greatly reduced by having a watchful eye on the MSP." She estimates that denials and incomplete claims have been reduced by 75% to 80%.

The MSP auditor is able to make sure all of that information is correct before it is billed, adds Brown. Here is what the department's Medicare MSP auditor does:

The MSP auditor is located in the main registration area, is an onsite resource for patients, and also is available by phone and email to the decentralized registration areas.

• The MSP auditor ensures the claim is accurate.

Some patients are unaware of being in a Medicare A bed status, for instance. "The auditor calls around to find if patients are in a Medicare A bed and irons out the wrinkles in the MSP," says Brown.

If a patient is occupying a Medicare A bed and comes in for an outpatient procedure, staff members need to make sure that they are billing that facility for their charges, she explains. "Otherwise we could get into a double-dipping scenario, or one of us could be denied," says Brown.

• She monitors lifetime reserve days, checks for entitlement for all patients over 65 years of age, and works closely with case management.

The facility's case management team uses the MSP auditor as a resource to investigate the patient's current Medicare entitlement status, the type of Medicare coverage, whether the patient is in a Medicare Advantage plan, and whether the patient has a Medicare supplement or other commercial insurance that should be primary.

"The MSP auditor also keeps a close eye on lifetime reserve days," she adds.

• The MSP auditor monitors aging unbilled accounts and helps gather needed information.

"With Medicare, we have a window of time to bill accounts," says Brown. "If there are accounts sitting in an unbilled status because the MSP is not correct, we can miss those windows of time." ■

HIPAA Regulatory Alert

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

HIPAA rules stay in place during disaster — Address privacy and security issues in plans

"We hold disaster drills and prepare for emergencies, but we never practiced total destruction of our facility," says **Tracy A. Clark**, MS, RHI, director of health information management and the privacy officer for Mercy Hospital of Joplin (MO).

Complete destruction is exactly what happened to her hospital when a deadly tornado hit the community in 2011. A total of 358 people were in the hospital. Five patients died when their ventilators failed after losing power when the auxiliary generators were destroyed, but all other patients and staff members survived.

"Because we are part of the Sisters of Mercy Health System, electronic records could be accessed by our sister hospital in Springfield," explains Clark. This access enabled staff members to access patient records and fax them to the hospitals to which patients were evacuated. A mobile hospital and command center, set up with the help of the corporate information technology division, allowed Clark's department to get up and running within a week of the tornado.

Although the initial activities in a disaster are to protect the lives of patients, families, and staff members, your IT disaster plan needs to take into account Health Insurance Portability and Accountability Act (HIPAA) or Health Information Technology for Economic and Clinical Health Act (HITECH) requirements. "We contacted the OCR [Office of Civil Rights] and CMS [Centers for Medicare and Medicaid Services] to obtain a waiver because we knew that paper records had been scattered throughout the area by the tornado," says Clark. "We then put a message on our website and in the local media asking community members to return any radiology films or paper records from the hospital to us." More than 100 pieces of radiology film were returned, including some that had reached Springfield, MO, 70 miles away.

Other messages from the hospital warned community members about the potential loss of personal information, not just from the hospital but from other businesses as well, and offered tips on how to protect themselves from identity theft. "We don't know how many paper records that contained protected information were lost, but we wanted to warn people of the risk," says Clark. The electronic records system in place at the hospital limited the number of records that were scattered, and the password and encryption systems in place ensured that the appropriate people accessed electronic records remotely.

Although the scene at a disaster is chaotic, it is the IT staff's responsibility to ensure that privacy and security rules are followed, says **Jacob K. Braun**, president and chief operating officer of Waka Digital Media Corp., a Boston-based technology and security management company. "You can't relax the rules during a disaster," he points out. "Patients rely upon a certain standard of care and respect for privacy at all times, especially during a disaster."

The challenge for IT staffs during a disaster is that it is an "all-hands-on-deck" approach to evacuating patients, providing care, and com-

EXECUTIVE SUMMARY

When a disaster strikes, the information technology staff and the privacy and security officers must ensure that patient information is protected. After the total destruction of Mercy Hospital in Joplin, MO, staff had to ensure continued security for data as other hospitals in the system accessed patient records to facilitate transfers.

- Notify the Office of Civil Rights and the Centers for Medicare and Medicaid Services when a disaster might result in loss of electronic data or paper records to obtain a waiver that can protect you from sanctions.
- Know where your paper records are stored and how many can be lost.
- Destroy paper records if no longer needed after scanning.
- Make sure personal mobile devices used in an emergency are secure and encrypted if they will transmit or receive protected health information.

municating with other caregivers, says Braun. "Clinical practitioners are not going to think about information security and may bypass security measures as they respond to emergency needs."

Personal mobile devices such as smartphones, tablets, and laptops might be used for documentation or to retrieve information in an effort to speed response, says Braun. "The use of personal devices must be addressed by the security officer in the development of a disaster plan so everyone knows if they can be used, in what circumstances, and with what tools such as encryption. *(See story on this page for more tips about use of a mobile device during a disaster.)*

Hospitals that are part of a health system might have the benefit of a centralized IT department or remote backup services at another facility, but single institutions or smaller health systems with facilities near each other might need a third party vendor to provide backup assistance, suggests Braun. "Make sure your vendor understands all of the privacy and security rules with which you must comply, even in a disaster," he says. "For example, Massachusetts hospitals have to comply with HIPAA, HITECH, and state regulations."

Assess your vendor's security in hardware and software solutions and when receiving or sending information, suggests Braun. "Hospitals want to be up and running quickly, so look at how you can recover your information," he says. "Does the vendor store and access data at the same security level you expect from your own IT department?" Be sure to ask for references from organizations that have had to recover information following a disaster, he suggests.

Another tip from Clark is the need to address paper backup material. "I was very lucky," she admits. As part of the process to switch to electronic records, a large number of paper financial and medical records were scanned into the system. "The scanning took place in a warehouse away from the hospital but in Joplin," she says. "I held onto the paper records after scanning was complete, then about six months before the tornado hit, I had them shredded. I can't imagine how many more paper records would be floating around if I hadn't destroyed them," she admits. Her advice is to trust the electronic information systems and not to hold onto paper you don't need. She adds, "Now, I scan, check, and destroy."

Sources

For more information about HIPAA/HITECH compliance in a disaster, contact:

• **Jacob K. Braun**, President and Chief Operating Officer, Waka Digital Media Corp., PO Box 52388, Boston, MA 02205-2388. Telephone: (800) 925-2180. Email: Jacob@wakadigital.com.

• **Tracy A. Clark**, MS, RHIA, Director of Health Information Management and Privacy Officer, Mercy Hospital of Joplin, 2817 St. John's Blvd. , Joplin, MO 64804. Telephone: (417) 781-2727. Email: Tracy.Clark@mercy.net. ■

Address mobile devices before a disaster

Encryption a necessity

When a disaster strikes, hospital personnel are focused upon patient care rather than compliance with Health Insurance Portability and Accountability Act (HIPAA) or Health Information Technology for Economic and Clinical Health Act (HITECH) rules. This "need for speed" might lead to use of personal mobile devices as a way to gather or transmit protected health information, points out **Jacob K. Braun**, president and chief operating officer of Waka Digital Media Corp., a Boston-based technology and security management company.

If a hospital allows the use of personal mobile devices on which the hospital has installed encryption software and provided access codes in non-emergency situations, there is no problem with their use in a disaster, points out Braun. "However, the decision to allow their use is not a decision that should be made during a disaster," he says.

If a hospital does not allow the use of personal mobile devices on a day-to-day basis, with appropriate encryption and access already in place, the disaster plan should address the use of personal mobile devices in an emergency. "You can choose to not allow it all, but if you choose to allow it during a disaster, you must identify how the devices can be used," points out Braun.

Although the simplest route to take is to ban use of personal devices, the reality is that people resort to what they know best and almost everyone has a personal mobile device they can use in an emergency, says Braun. The benefit of allowing the use of personal devices is immediate access to information, but the disadvantage is the process of encrypting the devices and setting up access, he admits. "You have to identify how you will encrypt the devices and limit use of the personal device to emergencies only," he says. "You also have to look at security of information received by mobile device as well as security of the information transmitted.

Because an IT department might not have the capability to encrypt phones at the time of a disaster, a better approach might be to stock

some extra devices that already are encrypted and available for use in a disaster, suggests Braun. "Many hospitals have devices used by on-call clinicians, so it is possible to add extras and make sure they are secure." ■

Audits ID security as top compliance problem

Security compliance is more of a challenge for the organizations included in the initial 20 Health Insurance Portability and Accountability Act (HIPAA) compliance audits than privacy compliance, according to information presented at a HIPAA security conference sponsored by the National Institute of Standards and Technology and the Office of Civil Rights. Most of the findings were related to the Security Rule (65%), followed by the Privacy Rule (26%). Non-compliance with the HIPAA Security Rule's administrative safeguards requirements accounted for 42% of the audit findings, technical safeguards accounted for 41% of findings, and physical safeguards represented 17%.

The six most challenging Security Rule compliance issues are:

- **user activity monitoring;**
- **contingency planning;**
- **authentication and integrity;**
- **media reuse and destruction;**
- **risk assessments;**
- **granting or modifying user access.**

Results of the audits show that smaller organizations have trouble establishing HIPAA compliance programs. Six of the 20 audited entities (30%) were small entities (e.g., $50 million or less in revenue), but these small entities represented 66% of the deficiency findings.

The top five privacy issues uncovered by the initial audits are:

- **personal health information uses and disclosures related to deceased patients;**
- **protected health information (PHI) disclosures and uses by personal representatives;**
- **business associate contracts;**
- **disclosures for judicial and administrative purposes;**
- **verification of the identity of those requesting PHI.**

Although initial plans called for an audit of 150 organizations in 2012, the plan is now to audit 115 organizations. The additional 95 healthcare organizations have been selected and are being notified. All audits are scheduled for completion by the end of the year.

The webcast of the OCR presentation on the results of the first 20 audits is online at http://1.usa.gov/McvQoa. ■

Detailed risk assessment addresses all breach risks

Websites, storage areas need to be included

Have you conducted a privacy and security risk assessment required by HITECH? While most people answer yes to this question, there's a good chance you haven't taken a close look at all data breach opportunities.

- **In June, Memorial Sloan Kettering reported a leak discovered in a routine audit by its Internet security team.** The protected health information (PHI) included patient names, phone numbers and, in some cases, social security numbers. The PHI was embedded in a computerized graphic presentation created by a Memorial Sloan Kettering researcher and displayed on two medical professional websites. Although the information was not visible on the presentation, if someone knew the data was present, the document could have been manipulated to show the data.
- **In April, Emory Healthcare reported the loss of 10 backup disks for a patient information system that is no longer in use.** The unencrypted disks were located in a storage area and contained information including some patients' social security numbers for 350,000 surgical patients treated between 1990 and 2007.
- **In April, the Utah Department of Health reported a breach that affected 780,000 individuals due to an outside hacker.**

Risk assessments often focus on more common risks that involve theft of laptops or inappropriate access through hospital-based computers, but a thorough risk assessment must look at all potential areas in which a breach can occur, says **Rebecca Herold**, CISSP, CIPP, CISM, CISA, FLMI, owner of Rebecca Herold & Associates, a privacy and security consulting firm in Des Moines, IA. One way providers can make sure they address all areas is to use the toolkit developed by National Institute for Standards and Technology (NIST), she suggests. (See resources at end of story for information about toolkit.) The most commonly overlooked areas in a risk assessment include:

- **Protection against outside hackers.**

"Many healthcare organizations have inadequate controls on their websites or servers to protect against hackers," says Herold.

As more hospitals offer online appointment registration and access to patient portals to see test results, the need for protection against hackers increases. Only 7% of healthcare data breaches reported in 2011 were related to hacking of information from an outside source, but as hospitals make more information accessible online, the risk

increases, Herold adds.

"Be sure your business associates have the same controls against hackers," she warns. "Many of the largest breaches have occurred with third-party business associates."

• Storage of old records.

"Every risk assessment should address an inventory of all storage locations for old records, both electronic and paper," suggests Herold.

In addition to listing the locations, a regular audit of the material should be conducted to be sure the information is accessible only to people who need access and to ensure the material is where it is supposed to be.

• Disposal of information.

"The process to destroy or dispose of information when no longer needed is one of the most overlooked issues in risk assessments," says Herold. "I've seen organizations spend a lot of money on efforts to keep people from accessing data inappropriately, then old computers or fax machines that store information are just thrown out or donated to other organizations without removing data."

"The process to destroy or dispose of information when no longer needed is one of the most overlooked issues in risk assessments."

Hospitals that allow staff members to access patient data on their personal mobile devices should remember that disposal of information on those devices needs to be included in a risk assessment, says Herold.

"If a hospital allows employees to store information on their mobile devices, policies need to be clear about how that data is removed when no longer needed."

• Tracking mobile device use.

As more hospitals implement programs that allow employees and physicians to use personal mobile devices to access protected information, be sure the risk assessment plan addresses the need to inventory and continually update reports on use of personal devices, suggests Herold. One of Herold's clients conducted an inventory at the start of a program enabling the use of personal devices and found 600 devices in use. Less than one year later, the number of personal mobile devices used by hospital staff had grown to 1,500.

"The speed of change with technology makes it necessary to update your risk assessment more frequently in some areas, such as mobile devices, than others," admits Herold. "One way to monitor and track use of personal devices is to require hospital-provided encryption software on the devices to enable access," she says.

Not only does this requirement give the information technology department a way to track who is using personal devices, but it also provides a way to identify potential misuse of access.

The best way to handle a risk assessment is to go beyond what is reported in headlines, suggests Herold. "A risk assessment is not just about compliance, it is a tool to improve privacy and security of our patients' data on an ongoing basis," she says. "This isn't just good for our patients; it's good for our hospitals."

r eSour c e/Sour c e

The HIPAA Security Rule Toolkit is a free resource developed by the National Institute of Standards and Technology. The self-assessment tool presents a series of questions in groups related to each of the HIPAA Security Rule standards and implementation specifications. To access the toolkit, go to http://scap.nist.gov/hipaa.

For more information about effective risk assessments, contact:

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HHS releases HIPAA audit protocol

Hospitals included in the remaining group of 95 organizations to undergo Health Insurance Portability and Accountability Act (HIPAA) audits this year can refer to the audit protocol just released by the Department of Health and Human Services' (HHS') Office for Civil Rights (OCR). The protocol includes 77 areas of evaluation for the HIPAA Security Rule and 88 for the HIPAA Privacy Rule and HIPAA Breach Notification Rule.

The protocol was developed after the pilot phase of the audit program, using information learned during the first 20 audits. This protocol most likely will not be the final protocol, according to Linda Sanches, senior adviser and health information privacy lead at OCR. Sanches says changes might occur following the completion of the remaining 2012 audits. Other changes might result as a result of the final version of pending modifications to the HIPAA privacy, security, enforcement, and breach notification rules. To see a copy of the current audit protocol, go to http://ocrnotifications.hhs.gov/hipaa.html. ■

To Determine A Patient's Payment Amount:	
ED	1. Look in the copay due field 2. Look at the patient's card 3. Look in the E-Coverage response history 4. Use table below
All other services	1. Review note from Insurance Verif. and Pre Registration 2. Review checklist in Epic 3. Use table below

SERVICE	DEPOSIT	SELF PAY
Imaging		
CT		
MRI		
Nuc Med/Pet Scans		
Mammo		
X-Ray		
Ultrasound		
Anti-Coag/Infusion/DTU		
Anti-Coag		
DTU		
Infusion		
ED		
ED Visit		
Surgery/Procedure		
Amb. Procedure		
L&D		
Delivery		

SOURCE: Legacy Health, Portland, OR