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## IN THIS ISSUE



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# Many patients misled on coverage, but patient access staff can help

*Plans with $20,000 deductible in marketplace*

Patient access employees probably believe that insurance companies have an obligation to fully inform consumers about the coverage they're getting. Unfortunately, this belief doesn't always translate into reality.

"It's easy to say that the payer should be doing this, and most do try hard to explain. But as benefit plans get more complex, members don't often fully understand their benefits," says **Jen Nichols**, senior director of revenue cycle operations at Kaleida Health in Buffalo, NY.

Nichols is seeing plans with an out-of-pocket maximum in the tens of thousands. "Unfortunately that is not uncommon these days. Where in the past a patient might have had a $2,000 maximum, now $20,000 plans are in the marketplace," she says. "Folks used to having a more robust benefit package are trying to adjust to this new reality."

Patient access employees at Ochsner Health Systems — Baton Rouge (LA) Region are seeing an influx of patients with plans ranging from major medical, limited medical, mini-medical, micro-medical, and medical discount. "These plans advertise themselves to the public as 'innovative,' but really, some are only good for catastrophic purposes," says **Elizabeth H. Broadway**, CHAM, director of patient access and business services.

## EXECUTIVE SUMMARY

Benefit plans are becoming increasingly complex, with deductibles as high as $20,000 in the marketplace. Members of the patient access staff are taking on the role of educating patients on their coverage.

- Some financial counselors are reaching out to patients in the community.
- Screening patients should occur as early as possible in the process.
- Being upfront about out-of-pocket costs results in less bad debt.

## Access reaching out to patients

Patient access staff must step up to fill the role of informing patients about their coverage, argues Nichols.

"For the last several years, having a really robust pre-arrival department was considered a best practice," says Nichols. This best practice means that patient access intervenes just prior to scheduled services or sometimes when patients are shopping for quotes.

This step is still important to do very well, she says, but Kaleida's patient access employees are taking it a step further. "There is a role for us to play in helping patients to understand their benefits even before the patient has presented on the pathway to services," says Nichols.

Financial counselors, called "navigators," now provide outreach in the community to assist patients in enrolling in Medicaid and exchange plans, even prior to needing healthcare services. Nichols says the outreach makes it less likely patients will present for catastrophic — and costly — events, since they'll presumably be getting better preventative care. "This will help patients to be healthier ahead of time, so they hopefully don't need us for a costly, catastrophic illness that may put both their personal finances, as well as hospital revenue, at risk," she says. If patients do present for a catastrophic illness, they will have the security of having some level of coverage to assist them.

Previously, patient access were stuck in a "reactive" mode, says Nichols. Staff waited for a patient to contact them or waited for a physician to refer them, before helping them to obtain coverage or understand their existing coverage. "We now have an opportunity to be proactive, to help patients enroll even before they need us. So when they do need us, they are well-covered," says Nichols. "That takes the anxiety off the patient. It is one less thing to worry about."

If patients present for services without insurance, the financial navigators still help them to apply and enroll in traditional Medicaid or any of the nine plans available through the state's exchange.

"We are not an insurance broker and we make no profit on this," Nichols explains. "We are trying to help patients sign up early for coverage and connect them with the right coverage plan."

## Earlier is better

Whether patients are presenting for services, or do not need coverage yet, patient access employees take the approach "the earlier in the process, the better," says Nichols.

Employees use an internally developed application to provide accurate, timely quotes to patients. "Resolving finances early on reduces stress on the patient. It also clearly reduces our cost to collect," says Nichols.

If no one educates patients on their coverage, it causes problems for the patient and the hospital, due to a longer time to collect, increased bad debt, and less reimbursement, says Nichols.

"Then there is the goodwill factor," says Nichols. "It's hard to quantify that. But if we are upfront with

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patients, they might not like what we tell them, but they believe we are a committed partner with them."

At Mercy Hospital in Springfield, MO, some patients consider cancelling surgery due to high out-of-pocket amounts. "We offer a low-interest bank loan and payment arrangements to enable them to go ahead with surgery," says **Rebecca Holman**, CHAM, patient access manager. *(See related stories what questions to ask patients at preregistration, below, how to determine if financial counseling processes are getting good results, p. 124, and good processes to help patients, p. 125.)*

**SOURCES**


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# Ask this question at preregistration

"Would you like to speak to someone about financial concerns?" This question is one of the most important ones to ask patients being preregistered, according to **Jen Nichols**, senior director of revenue cycleoperations at Kaleida Health in Buffalo, NY.

"Giving them the opportunity to speak with a financial counseling staff is the single best way to get them to understand their responsibility," she says. If patients have financial concerns or might qualify for assistance, staff will help them understand their options and apply.

There are many different resources for low-cost or free care that staff can connect patients with, in addition to traditional Medicaid or charity care, such as grants or free screening examinations provided by community organizations. "Patients need to understand we want them to get coverage as much as they do," says Nichols.

## Offer discounts

Offering prompt pay discount or extended payment plans are other ways to assist patients who have coverage but large patient responsibilities.

"It's certainly not mandated across the nation that hospitals have to offer discounts for patient responsibility after insurance," notes Nichols.

However, if you don't offer these options, a patient who is shocked to find he or she has a $20,000 deductible might end up paying nothing.

"We can't go back and unwrite a contract that they've signed," says Nichols. "But at least you can take the immediate crisis away from the patient." ■

# You should closely watch revenue cycle metrics

*Three items you should be tracking*

To determine if patient access processes for financial counseling are getting good results, **Jen Nichols**, senior director of revenue cycle operations at Kaleida Health in Buffalo, NY, keeps a close eye on these metrics:

• **The proportion of accounts in bad debt and charity care.**

"If you qualify somebody for charity who would otherwise not have paid their bill, you have moved somebody out of the bad debt into the charity bucket," she says.

• **The conversion ratio of patients initially classified as self-pay who are converted to a payer source at the point of billing.**

"We look to see the self-pay bucket go down and the conversion ratio go up," she says.

The organization's outreach program, which connects financial counselors to patients in the community, is too new to know its effect on hospital revenue. However, Nichols expects to see less bad debt and fewer self-pay patients.

"It's just a delayed presentation. We may be enrolling somebody this year who isn't going to need our services until next year," she explains.

• **Patient satisfaction scores.**

"Were you happy with the billing process?" A general question such as this on a patient satisfaction survey can give misleading information about patient access processes. Patients who are unhappy about their out-of-pocket responsibility are likely to report dissatisfaction, even if they received excellent service from patient access.

"Department leaders need to ask the types of questions that let them delineate exactly what aspects of the patient experience people are having trouble with," Nichols says.

Good communication and financial counseling processes can prevent patient dissatisfaction even if a large out-of-pocket responsibility is owed, says Nichols. For this reason, it's important that survey questions are worded correctly.

Nichols recommends asking questions such as: "Was the quote process prompt?" "Did you receive a written estimate?" "Did you understand the estimate?" and "Were you treated with courtesy?"

"That is the type of information I want to know about my front end," says Nichols. "The question, 'Were you happy with the dollar amount you were asked to pay?' is not in the purview of my access staff."

### Avoid unpleasant surprises

If patient access don't communicate with patients about costs early in the process, patients are likely to be dissatisfied and won't be shy about saying so in a survey, says Nichols.

"When you don't do a good job with those upfront discussions, then any amount owed is an unpleasant surprise at the end," says Nichols. "You run the risk of getting negative patient feedback."

Nichols recommends using focus groups to get feedback specifically about patient access processes: timeliness to care, ease of scheduling, access to information, and preparation prior to the encounter. "One of my favorite things I heard from a focus group was about the transparency of a price quote," she says. "We were often quoting a bottom line number — what the patient would owe out of pocket, total."

A patient observed that, in the absence of any context, that number was open to the interpretation of the patient as to whether it was a "good value" or not. "When we showed projected insurance payments, or any discounts offered, or even a payment plan schedule, the patients could put their responsibility in context and understand their contribution," says Nichols.

Kaleida Health's patient access staff are quick to offer patients a prompt pay discount or extended payment plan. "It's certainly not mandated that hospitals have to offer discounts for patient responsibility after insurance," notes Nichols. If you don't offer these options, however, a patient who is shocked to find he or she has a $20,000 deductible might end up paying nothing.

"We can't go back and unwrite a contract that they've signed," says Nichols. "But at least you can take the immediate crisis away from the patient." ■

## Finances are a top priority for access

Unfortunately, healthcare costs are often the first thing that comes to mind when someone gets sick, says **Elizabeth H. Broadway**, CHAM, director of patient access and business services at Ochsner Health Systems — Baton Rouge (LA) Region.

"We can counsel patients on the costs and financial expectations during the pre-registration call, but the resources are limited for the population that is underinsured," she says.

This issue results in increased cancellations at the point-of-service and high levels of frustration for the patient, due to a lack of other financial options, she reports. "Louisiana is one of the only states left that has an 'organized' charity care system," says Broadway. "Unfortunately, this is where the patients have traditionally ended up."

For these reasons, patient access staff members have made financial counseling a top priority. "This has become a staple item of our healthcare system," reports Broadway. "We advocate that the patient must be given the opportunity to make a detailed and informed decision regarding the financial aspect of their healthcare."

Patient access representatives take these steps:

- They sit with the patients in a private, confidential area to discuss what their needs are and what resources are available. This meeting occurs prior to their scheduled visits or at the day of their scheduled encounters.
- They explain the patients' current coverage and educate them on how the benefits will work.

Staff members begin by stating what the benefits are and then ask the patients if they are aware of the limited coverage provided by the plan.

"From there, we identify what the financial gaps are. We help cover these gaps with any assistance or resources that are available," says Broadway.

- Once the patients express that they would like more details on what to expect from a financial standpoint, staff members escort the patients to an available financial counselor.

### Fewer no-shows

Broadway says that obtaining accurate, verified data for all patient demographics is one way to prevent lost revenue.

"We are then able to seamlessly determine the eligibility and benefits of a payer and establish what the

anticipated financial requirements of the patient will be," she says.

Each patient must be financially cleared for services performed in a non-emergent, elective environment. "Performing this service ahead of the appointment date reduces the number of no-shows. It allows the cancellations to be filled ahead of time," says Broadway.

Patient access employees recently met with a woman who had a limited benefit plan and whose husband's job was reduced from a full-time to a part-time position. "They lost the benefits associated with his full-time employment. The wife exhausted all their COBRA benefits," says Broadway.

The patient began coming for services and soon realized that she was paying too much money for too little coverage. Staff referred her and her husband for qualification under a state-assisted HIPAA pool coverage plan.

"She has to pay a little more each month for the premium," says Broadway. "But she has comprehensive coverage for herself and her husband with much less out-of-pocket and much more peace of mind." ■

# Simple changes for service that `wows'

After a patient is registered, he or she always has someplace else to go. Do patient access staff members simply give some vague directions, or do they come out from behind the desk to help the patient? At The University of Tennessee Medical Center in Knoxville, registrars make a point of personally escorting many patients for testing.

"Some testing areas are close to check-in," says patient access manager **Tammy Mendenhall**. "We walk those patients to the lobby and direct them down the correct hall or elevator,"

This task takes only a minute or two, but it makes a big impression on patients. "Customer service surveys often contain comments about how registrar showed them exactly what elevator to take or walked them to the testing area," Mendenhall says. Here are other simple ways to improve service:

**• Avoid "sideline" conversations while registering patients.**

Hearing registrars talking to one another instead of the patient can make anxious, nervous patients feel as if they're not the focus.

"It's the responsibility of registrars to help the patient feel at ease," says Mendenhall. "Participating in sideline conversations takes the focus off the patient."

**• Ask marketing experts to "shadow" patient access staff.**

At the University of Tennessee Medical Center, the hospital's vice president of marketing and planning "shadowed" patient access staff, with the goal of improving service.

"She provided feedback on the consistency of team members introducing themselves, using closing scripts, and escorting patients to testing areas," Mendenhall says. "These are all simple steps that will move service from good to excellent!"

**• Staff members no longer ask patients, "What are you here for today?"**

"This is a question the registrars had grown into asking patients," says Mendenhall. "Patients would often answer by giving their symptoms, which can be embarrassing in the lobby area."

In most cases, the registrar already knew what the patient was coming for and was only confirming this information, but patients didn't realize that the registrar knew.

"Some patients were concerned, because they felt if we were asking then we didn't know anything about their test," says Mendenhall. Registrars now state the test or procedure, such, "I see you are scheduled for a mammogram." "Registrars should already know what scheduled patients are here for," she says. Each registrar closes the patient's registration by saying, "I have all your paperwork ready. Let me walk you to…".

**• Act on patient suggestions.**

When a patient at Mercy Medical Center in Oshkosh, WI, asked that a park bench be positioned near the hospital's chapel entrance so family could have somewhere to sit and rest, it was done almost immediately.

The patient's request had been submitted to one of the suggestion boxes that patient access departments keep at each point of entrance. Pads of paper are near the boxes, with a sign stating, "Your voice is impor-

## EXECUTIVE SUMMARY

Patient access departments are finding simple yet effective ways to provide excellent service. Some examples include:

- escorting patients instead of simply giving directions;
- avoiding "sideline" conversations when registering patients;
- letting patients know you're aware of the reason for their visit.

tant to us."

"We review each suggestion and address every one of them somehow," says **Connie Campbell**, director of patient access. "We have implemented many changes based on this feedback."

A more challenging request involved questions about out-of-pocket costs on medications when patients stayed overnight in a bed. "We implemented a letter to explain Medicare's definition of an outpatient, which now includes some patients who might be staying overnight," says Campbell.

**SOURCES**


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# Staff must be prepared before collecting copays

*Much less rework is needed*

Reduced collection cost and better patient satisfaction were the two major benefits of collecting copays at the time of service that were identified by patient access leaders at Cooper University Health System in Camden, NJ.

These steps were taken by the project team, which had representatives from patient accounts, patient access, pre-registration, physician billing, and training, before point-of-service copay collections were implemented:

1. A vendor was selected.

"Our final vendor selection was driven by the need for a robust, web-based application which would interface directly with our current registration system," says Randall Smailer, manager of patient access/quality assurance.

The system also needed multi-faceted reporting options and the ability to offer a patient portal for online payments. *(See related story, p. 127, on the department's implementation of online bill payment.)*

2. Detailed policies and procedures were written, and a comprehensive online training program was created.

A subgroup of the project team was charged with creating policies and procedures. The training department took on the task of developing the online training.

"This was considered the most efficient way to train a large number of staff, without requiring them to leave their work sites," says Smailer.

3. Every point-of-service site throughout the health system was visited by the "communication team," a subgroup of the project team.

"The primary concern on the hospital side was a change in culture, in having to ask patients for a copay prior to a hospital-based service," says Smailer. "This is the norm at a physician's office, but relatively new for a hospital procedure."

Some staff members also were concerned about using the software application, but they saw it was easy to use once it was presented to them in training. The team gave employees an overview of the copay collection project, covering objectives, benefits, training, copay determination methods, and collection tools to be utilized.

"Users are given the option of reviewing service type benefits from online portals, or for more complicated procedures, using an online price estimating tool linked to our managed care contract," says Smailer.

4. Since the new software allowed credit cards to be swiped from any user's computer, a count was taken and swipe pads were ordered.

5. The new process was thoroughly pilot tested.

This step ensured that the process was relatively problem-free before being introduced throughout the health system.

"We wanted to monitor the effects of using the new application in all stages of the revenue cycle," says Smailer. "So we piloted it in pre-registration, the hospital cashier's office, and cash applications in the hospital billing office."

6. The new copay collection process was rolled out to most hospital-based service areas.

Departments new to collecting copays were provided with safes and petty cash to make change.

"The physician side of the health system began with

## EXECUTIVE SUMMARY

Patient access leaders at Cooper University Health System did extensive pilot testing and educated staff before rolling out point-of-service copay collections.
• A subgroup of the project team created policies and procedures.
• The training department developed online education.
• Staff members no longer need to manually enter payments.

a phased rollout strategy, as they replaced their old credit card machines with the new point-of-service collection software," says Smailer.

### Less rework needed

Employees now enter payments with ease, and manual processes such as the need to send hard copies of payment logs have been eliminated.

Because the new process transitioned patients who were expected to pay the hospital cashier over to paying at their point of service, there has not yet been a notable increase in collections, reports Smailer. "We are just starting to venture into new areas that didn't collect copays previously, such as heart station, sleep study, gastro, and pulmonary," he adds.

However, duplication of efforts and redundancies have been greatly reduced. "At the five-month point into our implementation, we are very pleased with the results," says Smailer.

Before the point-of-service collection tool, each area responsible for copay collection compiled a daily copay log and forwarded it to cash applications in the hospital billing office. Payment posters manually entered every payment.

"Since our new process has been implemented, front-end staff can effortlessly collect payments," says Smailer. "These are batched nightly and automatically posted to the patients' accounts the following day."

**SOURCE**

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# Get ready! Your patients soon will pay bills online

At Cooper University Health System in Camden, NJ, patients no longer need to make a special trip to the hospital cashier to pay their bills. Instead, they have a "one-stop shopping" experience.

"We have installed point-of-service collection areas where the patient will be receiving their treatment," reports **Randall Smailer**, manager of patient access and quality assurance. "We are now beginning to expand to new areas that we were not previously collecting copays."

Five months after implementing a point-of-service collections tool, Cooper University Health System is taking the next step. The organization's patient portal will allow patients to pay bills online, view current and past statements, and update demographic and insurance information.

The patient portal team started by reviewing other hospital portals created by its vendor, along with those of similar healthcare facilities in the area. "This helped us to envision what our portal should look like," says Smailer.

Customizations were added, such as sample hospital and physician statements and the ability to review past billing history. "As the portal is developed, team members test for ease of use, typos, and any broken links or inconsistencies," says Smailer.

All patient billing statements will include a link to the portal when it goes live in late 2013.

"We expect to see increased patient satisfaction with the ability to pay bills online at their own convenience; and a decrease in cash application payment posting, since online payments will self-post," says Smailer. ■

# Stop `no auths' due to changed procedures

When hospital VIPs at Lourdes Health System in Camden, NJ, expressed concern over the fact there were so many claims denials for no authorization, **Joan Braveman**, corporate director of patient access, asked for data. She began studying the "no auth" denials.

"I kept hearing we had too many denials, but I wanted to get some good data on what was going on," she says. Once data were obtained, Braveman noticed a cluster of accounts that did, in fact, have authorizations but were still denied for no autho-

EXECUTIVE SUMMARY

Often, claims are denied for failure to obtain the required authorization, simply because a different clinical procedure or diagnostic was done. Patient access leaders at Lourdes Health System addressed these denials with these approaches:

• Cardiologists were informed about the denied claims.

• The director of OR services and surgeons were asked to notify payers of procedure changes.

• New processes were put into place to obtain authorizations prior to service.

rization. Further analysis of the accounts showed that authorizations had been obtained for specific services, but other services were provided.

"In many cases, the surgeon or cardiologist had obtained an authorization, and then performed a different service," she says. "Since no one notified the payer of the changes, the claims were denied."

### In-person visits

Now that one cause for many of the no authorization denials was identified, an action plan needed to be developed. Since most of the services were provided in either the OR or the heart catheterization lab, Braveman decided to educate the departments. She went to the cardiology groups in person to inform them of the reason so many of their claims were being denied.

"In some cases, it was something as simple as obtaining an authorization for a cardiac cath, and then the cardiologist finds the patient needs a stent," she says. "If they don't notify the payer of that change, the claim will be denied."

Next, Braveman worked with the director of OR services so she could educate the OR staff about the problem. Now, if they see a patient is scheduled for a certain procedure, but the surgeon does something different, OR services staff notify the payer of the change in procedure so the authorization can be obtained. In some cases, the original procedure didn't require an authorization, but the procedure provided does require an authorization. Again, the physicians' offices are asked to notify the payers within 48 hours, as required by some contracts.

Braveman also asked the billing office send her all "no-auth" denials that do have an authorization number in the system, so these can be addressed and appealed right away.

### Very costly writeoffs

In addition to the claims denials, Braveman learned that a large number of write-offs were occurring for cardiology services.

"Since cardiology procedures are generally costly procedures, I decided to do further research on these accounts and write-offs," she says.

In some cases, it was found that the patient came in for a lead replacement in an automatic implantable cardioverter defibrillator (AICD) and the cardiologist decided there was a need to replace the AICD, but no one was informing the payer.

Braveman alerted the cardiologist groups about this costly problem. "I told them, 'If the authorization gets changed for the service provided, everybody gets paid,'" she says.

She told the groups about two recent cases that were written off, which each cost the hospital about $30,000 in reimbursement. One case involved a generator replacement with an authorization in place only for removal. The other case was a pacemaker removal which didn't have an authorization in place. "For either of those cases, a phone call at the right moment to the insurance company would have taken care of it," she says.

Because Braveman educated the cardiology groups, there have been fewer "no-auth" denials for cardiology patients. In addition, new processes were put in place to obtain authorization before the patient presents for services, and for patients transferred for cardiac catheterizations.

"We were getting bad information from the sending hospital on the patient's insurance, and then we weren't getting paid," explains Braveman. *(See related stories on claims denials involving Medicare, p. 128, and avoiding costly radiology writeoffs, p. 129.)*

**SOURCES**

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# Medicare is primary, but claim still denied?

Sometimes an insurance verification system says a patient's Medicare coverage is secondary, but patient access staff members know otherwise. **Rita Ascencio**, insurance manager at Lourdes Health System in Camden, NJ, doesn't just ask patients to go home and straighten it out with Medicare. Ascencio makes the call for them and asks the patient to resolve the matter right away.

"By dialing the number and handing them the phone, we know for sure that they are letting Medicare know," she explains. "Only the patient can do that. And if something comes up in the con-

versation that the patient needs help with, we can become involved."

In some cases, Auto is still listed as the primary payer due to a car accident the patient had many years earlier. In other cases, the patient's spouse was still working when the patient became Medicare-eligible, and the spouse's coverage is still listed as the primary.

These Coordination of Benefits (COB) issues are the number one reason for claims denials at Lourdes. "A lot of that is between Medicare and Blue Cross, because they do a lot of finger pointing," says Ascencio. "Each payer says the other is the primary."

One problem is that Blue Cross requires that each subscriber complete a COB form once a year, asking about other coverage. If the patient has not completed the form, the claim will automatically be denied for COB by Blue Cross, even though Blue Cross is actually the patient's primary.

To stop these denials, staff members now ask every patient with Blue Cross to complete the form, and it's faxed to Blue Cross directly. Associates scan a copy of the form into the document management system, so if the billing office gets a denial for COB, they can just pull it up, print it, and mail it in with the claim.

The form needs to be signed by the subscriber, however, and that individual isn't always there to do so. "We make it as easy as we can. We give them an envelope to mail it in," Ascencio says.

### Notation in system

**Joan Braveman**, corporate director of patient access, estimates that about 700 denials occurred in Lourdes' three emergency departments (EDs) in the previous six months, comprising 50% of all claims denials.

"Where we have the biggest issue is the ED: Sometimes you just don't have the time to be as thorough as needed," says Braveman.

If registrars know that an ED patient's Medicare is the primary, they put a note in the system stating, "This is definitely a Medicare primary. The patient's pneumonia has nothing to do with the broken arm he sustained in the auto accident."

The lead registrar in the ED reviews accounts to see if any denials involving Medicare can be avoided. "We see if there is any opportunity to clean up the account," says Braveman. "We have a bill hold of four days. So anything we do before then, other than causing rework on our part, is 'no harm, no foul.'" ■

# Stop needless and costly write-offs

*Hundreds of thousands in revenue at stake*

A simple communication process has reduced writeoffs by hundreds of thousands of dollars at Milwaukee-based Wheaton Franciscan Healthcare.

"We had a huge problem with radiology procedures changing, but we have resolved the issue," says **Kim Gehl**, manager of patient access, central scheduling, and central precertification.

Patient access leaders worked with the radiology department and developed a communication tool. This form is one that the servicing department completes and faxes to the central precertification department. They do this step anytime the procedure changes from what was authorized.

"The department knows what was authorized, as that information is provided to the servicing department," Gehl explains." *[The form 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.]*

These steps are taken when a procedure changes from what originally was authorized:

1. The fax from the servicing department is received in central precertification.

"The form is faxed the same day the new procedure was done," she says. "This notification is a trigger to the precertification department to update or obtain a new authorization."

2. The precertification rep contacts the insurance company to obtain a new authorization for the new procedure or additional service.

3. The information is documented in the billing system.

### Team effort needed

At Danbury (CT) Hospital, patient access associates strive to offer customers same-day scheduling if at all possible, reports patient access director **Cindy Thomas Lowe**, CHAM. This creates challenges in obtaining the necessary preauthorization, however.

"Most times, we are able to accommodate the need," Lowe says. "It takes a team. Some of the challenges are required test preparations, precertification in order to get paid for the testing, and then making sure demand can be met."

The team effort involves scheduling with a member of the department where the test will be performed,

and financial clearance to verify benefits and review authorization needs. "Usually, a nurse from the physician's office is available for a quick peer-to-peer [consultation]," says Lowe.

The hospital has found that its freestanding facilities have the competitive edge on same-day testing.

"We are trying to meet the demand to so that physicians and patients look to us for their service," says Lowe. "Physicians usually drive this sort of testing. We need to market the ability to take care of their patients." ■

# More evidence of Medicaid `churn'

*Access can help patients keep coverage*

Patient access employees often help patients determine eligibility for Medicaid coverage, which in many cases means lost revenue is prevented. However, patients don't always keep the coverage they obtain, even if they remain eligible.

In fact, the average Medicaid beneficiary is covered for only part of the year, leading to poorer health and higher-cost episodes of care, according to a new report from the Association for Community Affiliated Plans.[1]

This "churn" results in millions of otherwise-eligible Medicaid beneficiaries to be removed from the program, due to paperwork issues or small, often temporary, changes in income. Here are key findings of the report, which used new data to calculate the average monthly costs for persons enrolled in the Medicaid program:

• The average monthly cost to the Medicaid program is $345 for adults enrolled in Medicaid for 12 months of the year, compared with $597 for those who are enrolled for just one month.

• There are significantly lower costs for children who are continuously enrolled, with an average monthly cost of $110 for children enrolled in Medicaid for 12 months of the year, versus monthly costs of $151 for those enrolled for just one month.

Excessive Medicaid churning, when patients are dropped from Medicaid even if they are eligible and must re-enroll, has two consequences for hospitals, says **Leighton Ku**, PhD, MPH, the report's lead authors and director of the Center for Health Policy Research at George Washington University in Washington, DC. "If patients are uninsured when they arrive for care, the hospital must decide whether to provide care and perhaps not be paid by Medicaid, or to deny care, which is also a problem," says Ku.

Even if Medicaid eventually pays, reimbursement might be delayed because of the additional time needed to process an application, notes Ku. "Also, many hospitals have staff who can help patients apply for Medicaid," he adds. "They have more work to do when they must help patients this way."

If state Medicaid agencies either extend eligibility periods or make it simpler for patients to renew their enrollment before they need medical care, says Ku, then both problems can be avoided.

Renewal of Medicaid is largely a responsibility of the state Medicaid agency and the Medicaid enrollee, notes Ku. "Hospital staff might be able to check if patients have renewed their Medicaid coverage," he says. "But it is often impossible for hospital staff to know when a patient's certification period expires, and patients often aren't sure, either."

## New ways to help

Ku says that as the Affordable Care Act insurance expansions roll out, patient access staff have new opportunities to help patients obtain coverage. From Oct. 1, 2013, to March 31, 2014, there will be an open enrollment period for the new health insurance marketplaces.

Many patients not eligible for Marketplace coverage or subsidies still might be eligible for Medicaid or the Children's Health Insurance Plan, says Ku. Ku says patient access employees can help in these ways:

• giving advice to patients about how to apply using the new state-specific websites;

• obtaining training to become certified application counselors, who can more directly help enroll patients apply for the health insurance marketplaces;

• helping patients to understand all the different options.

"They may be particularly helpful in explaining some of the more complicated aspects of the market-


EXECUTIVE SUMMARY

Patient access employees often help patients to obtain Medicaid coverage, but in many cases, Medicaid-eligible patients lose their coverage. As a result of the Affordable Care Act insurance expansions, patient access staff can do the following:

• give advice to patients on how to apply on state-specific websites;

• help patients determine their choice of insurance plans;

• explain differences in premiums, deductibles, and copayments.

places, such as the differences in premiums, deductibles, and copayments available with each plan," says Ku.

REFERENCE

1. Ku L, Steinmetz E, Bruen BK. Continuous-eligibility policies stabilize Medicaid coverage for children and could be extended to adults with similar results. *Health Aff* 2013; 32(9):1,576-1,582.

**SOURCE**

• **Leighton Ku**, PhD, MPH, Director, Center for Health Policy Research, George Washington University, Washington, DC. Phone: (202) 994-4143. Fax: (202) 994-3996. Email: lku@gwu.edu. ■

# NAHAM joins social media sites

Taking on the latest form of social media, the National Association of Healthcare Access Management (NAHAM) has announced the arrival of Twitter and YouTube to its media landscape. You can follow the Twitter @MyNAHAM to get updates on policy changes, healthcare acts, industry technology changes, and certification/membership reminders and updates.

Also new is the NAHAM YouTube Channel. Go to YouTube to check out a new certified healthcare access manager (CHAM) and certified healthcare access associate (CHAA) promotional video, including testimonials from CHAMs and CHAAs touting the value of the certification, the process of getting certified, and the recent NCCA accreditation seal of approval. You can view this video at http://bit.ly/13hTR6U.

If you have something you would like NAHAM to post, email the association at info@naham.org. ■

# Guidelines updated for discharge planning

Continuing to emphasize the importance of discharge planning and preventing unnecessary readmissions, the Centers for Medicare & Medicaid Services (CMS) has issued a revised set of Discharge Planning Interpretive Guidelines that surveyors will use to assess a hospital's compliance with Medicare's Conditions of Participation.

"There is increased emphasis on discharge planning by CMS, and these revised guidelines attest to the importance of a good discharge plan and a smooth transition, which can help to prevent unnecessary readmissions," says **Sue Dill Calloway**, RN, MSN, JD, CPHRM, CCM, CCP, president of Patient Safety Education and Consulting in Dublin, OH. "CMS is encouraging hospitals to develop a discharge plan for all inpatients, whether they are Medicare recipients or not."

The 39-page document outlines what CMS expects hospitals to do in order to comply with the Conditions of Participation regulations and interpretive guidelines and includes instructions on what the surveyors should assess when they review hospital records. They include specific criteria for evaluating patients, creating a discharge plan, and improving transitions from the hospital to home or another level of care.

**Jackie Birmingham**, RN, MS, vice president emerita, clinical leadership for Curaspan Health Group in Newton, MA , says, "Surveyors will be looking for documentation that hospitals are complying with the Conditions of Participation and initially will select a group of charts to review for evidence of discharge planning evaluation activities. If they see a pattern of non-compliance, they may review more charts, order the hospital to create an action plan for improvement, then come back for another review." Ultimately, not being in compliance could lead to a loss of Medicare funding, she adds.

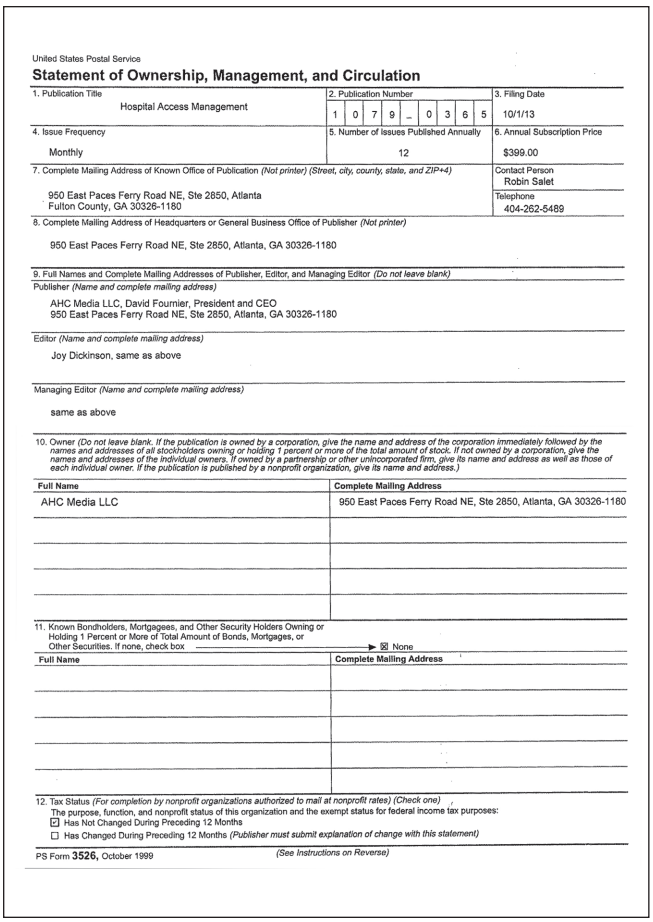
Birmingham suggests that managers familiarize themselves with the guidelines and what the surveyors will be checking and use them as a guide for developing best practices for patient care and transitions.

New in this version of the Interpretive Guidelines are what CMS call "blue boxes." The "blue boxes" make suggestions that hospitals can use in improving discharge planning and care transitions.

For the first time, CMS asks surveyors to employ the tracer methodology on several closed and open inpatient records to determine if hospitals comply with the Conditions of Participation. *(To read the guidelines, go to http://go.cms.gov/15Wo9f5.)* ■

## COMING IN FUTURE MONTHS

- Save money on training and education costs
- What to say to "price-shopping" patients
- Use career ladders to stop high turnover
- Avoid disasters when computers are down



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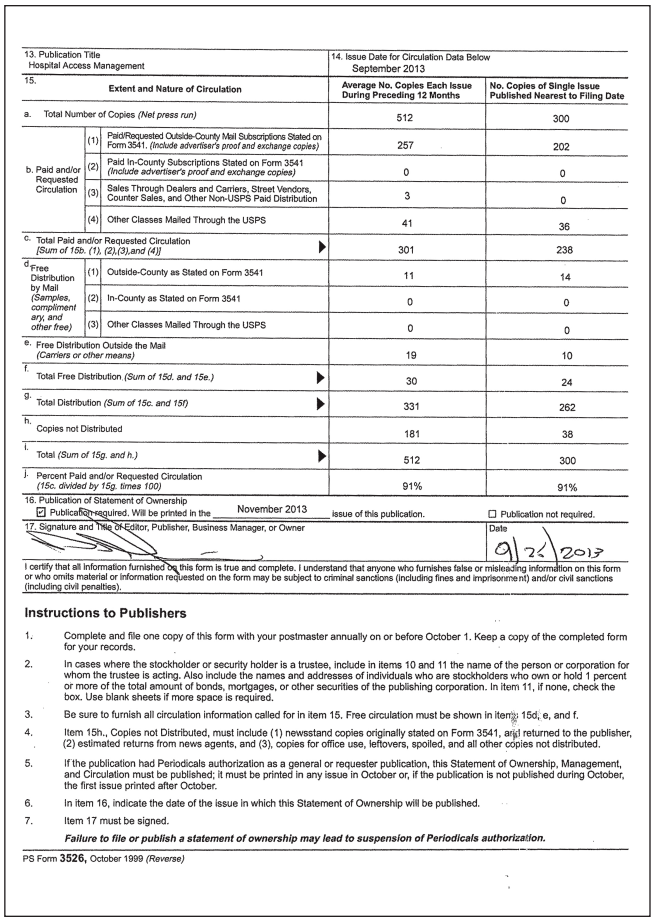

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HIPAA Regulatory Alert

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

# Compliance accountability chains put you at risk and can complicate contract negotiations

Risk managers are doing the right thing when they try to include Health Insurance Portability and Accountability Act (HIPAA) compliance in vendor contracts, but they might meet resistance if the requirements are too onerous. The key will be finding the sweet spot where you have protected your interests as much as possible without making the contract untenable to business associates, experts say.

Resistance most likely will come from smaller companies, says **C. Jason Wang**, MD, PhD, associate professor of pediatrics at Stanford University in California. Wang recently wrote in the Journal of the American Medical Association (JAMA) that the 2013 HIPAA omnibus final rule creates an "unfunded mandate" on startup companies that might not have the wherewithal to negotiate business associate agreements.[1]

In the *JAMA* paper, Wang and his co-author call for additional guidance from the Department of Health and Human Services (HHS) on how contracts between healthcare entities their business associates should be construed. The final rule creates an accountability chain that includes business associates and their downstream subcontractors, Wang writes, but it does not account for what he says could be strong resistance from business associates.

Wang tells HIPAA Regulatory Alert that providers' worries about accountability could have the unintended consequence of limiting innovation and narrowing the field of companies with which a hospital is willing to work. If the hospital insists on strict compliance with HIPAA, evidence that the requirements have been passed down the line to subcontractors, and indemnity for violations, inevitably some companies will balk and say they cannot take on that responsibility, he explains. *(See the story on p. 3 for suggested contract clauses.)*

"I really worry that if this HIPAA regulation is interpreted too far, it's going to impede innovation and get in the way of providers working with outside companies," Wang says. "That will be terrible for healthcare."

Conflicts might be inevitable, but the provider still must follow the law and include contract clauses to protect itself from liability, explains **Stephen Wu**, JD, a partner with the law firm of Cooke Kobrick & Wu in Los Altos, CA. The HIPAA rule explains most of what should be required of business associates, but Wu advises risk managers to take a stricter approach in some areas. The rule requires that business associates notify the provider of a breach within 60 days, for example, but he advices hospitals to require must quicker notification. He has worked with one hospital that successfully negotiated a two-day notification from a data management company.

"You're probably going to get something more than two days, but it should be way south of 60," Wu says.

The flow-down requirement for subcontractors can be the stickiest negotiating point, Wu says. Flow-down means that once you contract with a business associate, your requirements for HIPAA compliance must be included in the contracts with any subcontractors and their subcontractors

Including flow-down is not optional, Wu says, but you have some discretion in what you flow down. You must consider your contract requirements not only in terms of whether the business associate is able to comply but also whether its

## EXECUTIVE SUMMARY

Providers are accountable for the compliance of all downstream contractors with the Health Insurance Portability and Accountability Act (HIPAA). Vendors might balk at some efforts to ensure compliance.

- Covered entities can be responsible for the violations of business associates.
- The risk of liability is higher if the associate acts as an agent for the hospital.
- Some flexibility is necessary when negotiating HIPAA compliance clauses.

subcontractors can. "There are provisions that, in theory, should be flowed down to the business associates but which really aren't necessary when you consider the nature of the work. If the associate is handling patient data in a way that never involves them getting direct queries from patients, you could skip the provision about the associate being required to respond to requests by a certain time," he says. "You could take that off the table so they don't resist having to promise compliance on something they never do. But you could replace it with a clause saying they will cooperate fully if the patient makes a request to you and you need that information from them."

Money is always a sensitive topic, so indemnification and who pays for the breach of the protected health information can be difficult during negotiation, Wu says

In Wu's experience, the biggest controversy in these contract negotiations is the vendors claiming that they are not business associates at all. Contractors will argue that, for example, they merely maintain access to digital information for the provider but never open the files or have any knowledge of their contents. They will say that for that reason, they should not be considered business associates.

"You have to push back and tell them that because they are maintaining protected health information over time," Wu says. "That is the HHS decision, and they can't argue that point."

Wu advises risk managers to include a clause in the contract in which the vendor acknowledges being a business associate, along with a separate agreement to follow the compliance guidelines provided by the hospital.

One attorney urges risk managers not to go overboard with HIPAA compliance in contract negotiations. The legal risk to hospitals from missteps by business associates often is overstated, says **Brad Rostolsky**, JD, an associate with the law firm of Reed Smith in Philadelphia who has worked with healthcare providers to ensure data security. There is a risk of flow-down exposure, but that risk is significant only when the contractor is acting as an agent of the hospital, Rostolsky says.

"It is not true that contractors are generally on the hook for the actions of their business associates," he says. "We don't always have to negotiate as if something terrible is going to happen somewhere down the line and we're going to be liable to a great extent if we don't have a clause saying otherwise."

If a business associate is an agent under the federal common law of agency, then the covered entity is on the hook for the missteps of the business associate with regard to actions performed as an agent, Rostolsky says.

"When people try to implement more onerous language regarding indemnification and liability with business associates, I'd say that concern is valid up to a point, but may be a little misplaced," he says. "Don't be surprised when some of your associates come back to you and say that because of the cost of compliance they're going to have to raise their prices, or they're not going to be able to give you the indemnification you prefer."

Rostolsky advises structuring the contract up front so that, to the extent possible, the business associate is not an agent. To do so, the business associate must not be subject to direction by the covered entity on an ongoing basis. He cautions, however, that a single-minded focus on obtaining indemnification or other HIPAA concessions can backfire. "I've told people on both sides of this issue that if you push too hard, you can negotiate yourself out of business," he says. "Both parties in this negotiation have valid concerns and parameters for what makes good business sense, and you have to find somewhere to meet in the middle."

Covered entities also should be comforted by the fact that the government is going after business associates directly for HIPAA violations, Rostolsky says. That action doesn't mean they can't drag the covered entity into the fray as well, but Rostolsky says that will not be automatic if regulators can see that the associate was the responsible party and the covered entity acted properly in trying to ensure that the associate was in compliance.

As the Office of Civil Rights (OCR) continues enforcement activities against business associates, Rostolsky expects that "it will become implicitly clear that when a business does something improper, OCR will not hammer the covered entity for that unless there is an agent relationship."

## REFERENCE

1. Wang CJ, Huang D. The HIPAA conundrum in the era of mobile health and communications. *JAMA* 2013; online Aug. 26. Accessed at http://jama.jamanetwork.com/article.aspx?articleid=1732507.

## SOURCES

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• **C. Jason Wang**, MD, PhD, Associate Professor, Stanford University, Stanford, CA. Telephone: (650) 736-0403. Email: cjwang1@stanford.edu.
• **Stephen Wu**, JD, Partner, Cooke Kobrick & Wu, Los Altos, CA. Telephone: (650) 618-1454. Email: swu@ckwlaw. ■

# Contract clause samples for HIPAA chain

These sample contract clauses for ensuring business associates comply with the Health Insurance Portability and Accountability Act (HIPAA) are provided by **Stephen Wu**, JD, a partner with the law firm of Cooke Kobrick & Wu in Los Altos, CA:

**• Acknowledgement of Business Associate Status.**

Business Associate Status. The parties acknowledge that in connection with Services provided to Customer, Vendor is a "business associate" within the meaning of HIPAA. Vendor will comply with all requirements of HIPAA applicable to business associates in connection with the provision of its Services."

**• Security obligation tied to HIPAA Security Rule.**

Sample 1:

Business Associate agrees to: . . .

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;…

Sample 2:

In delivering Services to Customer, Vendor will maintain reasonable and appropriate administrative, technical, and physical safeguards to comply with the HIPAA Security Rule, 45 C.F.R. §§ 164.302-164.318, including by the officers, members, employees, contractors, and subcontractors of Vendor.

**• Security obligation untethered from a specific reference to the HIPAA Security Rule.**

Vendor will maintain administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Services provided to Customer and the Customer Information stored on Vendor's systems; … ■

# Prepare now for coming HIPAA security audits

It won't be long before someone knocks on your door and says it is time for a Health Insurance Portability and Accountability Act (HIPAA) security rule audit. What you do between now and then can determine how well that visit turns out for you.

The government is refining its audit protocol after testing it at 115 facilities, notes **Bruce D. Lamb**, JD, a shareholder with the Gunster law firm in Tampa Bay, FL. The Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) has stated that a permanent security audit program will begin Oct. 1, 2014. Some audits will be performed earlier than that as the OCR fine tunes its procedures.

"I expect some audits will be performed this year, with probably a pretty aggressive approach," he says.

The entities that are currently subject to audits are those that have certified compliance with the meaningful use criteria for electronic health records and received government funds for meeting that benchmark. During the testing, the procedure involved notifying the covered entity of an audit date, followed by an on-site inspection. There is no set time period for the length of the audit, but in the test audits so far, auditors were on-site for as long as five days.

The audit will begin with an interview of the privacy officer, and then the auditors will want to look at sample documentation. "They're not going to look just at rules and policies. They may ask for instances in which you released records to someone other than a patient," Lamb says. "Then they will check the adequacy of the documentation, whether you followed all the requirements to the letter."

Risk managers can use that same process in a mock audit to check their HIPAA compliance, Lamb suggests. A mock audit should include questioning hospital employees about policies and procedures for HIPAA compliance, because the real auditors certainly will. "They're not going to just look at your paperwork and talk to the compliance officer, the most knowledgeable person in the place about HIPAA," Lamb says. "They're going to walk up to medical records clerk and ask about certain tasks should be handled, and that person needs to be comfortable answering correctly. Most people need to be trained for that, or they'll trip up."

Lamb expects the HIPAA auditors to begin with

## EXECUTIVE SUMMARY

Providers should plan now for the Health Insurance Portability and Accountability Act (HIPAA) audits that begin on a permanent basis Oct. 1, 2014. Different strategies are possible for having your organization ready when it is time for an audit.

- Some audits will happen much earlier as regulators refine the process.
- Large providers likely will be the first targets.
- Auditors might be on site as long as five days.

the largest covered entities, hospitals, rather than smaller providers such as physician groups. To prepare for audits, the first obvious concern is having your organization in compliance with HIPAA. That compliance includes having a HIPAA privacy officer.

Covered entities should review each of the obligations in the test auditing process, Lam advises. The protocol is available online at http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/protocol.html. Conduct a self-assessment for compliance and correct any deficiencies, and create a specific plan of correction for anything that cannot be resolved immediately.

"Business associate agreements will be a target in these audits. You're going to need to provide them a list of your agreements, and I think some hospitals are going to be lagging in this area and not able to hand those over in the correct form," Lamb says. "HITECH [Health Information Technology for Economic and Clinical Health rule] required a lot of changes in your business associate agreements, and I'm not sure everyone went back and revised those. There will be a focus on anything that has changed recently, and the biggest thing there is HITECH."

**SOURCE**

• **Bruce D. Lamb**, JD, Shareholder, Gunster, Tampa Bay, FL. Telephone: (813)222-6605. Email: blamb@gunster.com. ■

# Advocate sued over large data breach

Advocate Health Care in Downers Grove, IL, and a subsidiary, Advocate Medical Group, are facing a state class-action lawsuit filed on behalf of two named plaintiffs and four million people whose protected health information (PHI) was taken along with four desktop computers in a burglary in July.

Advocate reports that the computers were password-protected but not encrypted. In a statement released after the breach was made public, an Advocate spokeswoman said Advocate had been working to encrypt its PHI since 2009.

A 12-page complaint in Cook County Circuit Court in Chicago alleges negligence, deceptive business practices, invasion of privacy, intentional infliction of emotional distress, and consumer fraud, all violations of Illinois law. Advocate's errors included "its use of nonsecure, unencrypted computers and software to maintain the private and confidential patient data," the complaint alleges.

The lawsuit requests a jury trial and judgment of an unspecified dollar amount for actual damages, costs, and other relief the court deems appropriate. According to the complaint, the plaintiffs' records were part of the July 15, 2013, data breach at an administrative office of the 1,100-plus physician Advocate Medical Group in Park Ridge, IL.

Advocate reports that the breach included more than four million records, making it one of the largest breaches by a healthcare provider since the federal government began requiring public reporting of larger healthcare records breaches in 2009. The breach is being investigated by the Office of Civil Rights of the Illinois Attorney General's office. ■

# Agencies release model notices of privacy practices

Covered entities can now choose from three new models of Notice of Privacy Practices documents to maintain Health Insurance Portability and Accountability Act compliance (HIPAA).

The Department of Health and Human Services Office for Civil Rights (HHS OCR) and the National Coordinator for Health Information Technology released the model notices recently. Those agencies noted that they were created based on input from consumers and key stakeholders, and they reflect recent regulatory changes in the HIPAA Omnibus Rule. The notices come in three styles and are customizable, allowing providers to enter their own information prior to distributing and posting to the web.

The agencies said many entities have asked for additional guidance on how to create a clear, accessible notice that their patients or plan members can understand. In response, the agencies have provided separate models for health plans and healthcare providers. The three options are:

• Notice in the form of a booklet, or a notice with the design elements found in the booklet, but formatted for full-page presentation.

• A layered notice that presents a summary of the information on the first page, followed by the full content on the following pages;

• A text-only version of the notice.

The models reflect the regulatory changes of the Omnibus Rule and can serve as the baseline for covered entities working to come into compliance with the new requirements. In particular, the models highlight the new patient right to access their electronic information held in an electronic health record (EHR), if the provider has an EHR in their practice. Covered entities may use these models by entering their specific information into the model and then printing for distribution and posting on their websites.

More information on the privacy notice models, including templates to use in creating your own, is available at http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html. ■

Wheaton Franciscan Healthcare

**Same Day add on or Additional Medical Imaging Service Provided**

FAX: 414-527-5405
Phone: 414-527-5406

**Is this a SAME DAY add on? _____ Is this ADDITIONAL TESTING?_____**

## Site: Check One:

____Wheaton Franciscan - St. Joseph
____Wheaton Franciscan - Elmbrook Memorial
____Wheaton Franciscan - Midwest Spine and Orthopedic Hospital/Wisconsin Heart Hospital
____Wheaton Franciscan - Wauwatosa
____Wheaton Franciscan - Brown Deer
____Wheaton Franciscan Healthcare - St. Francis
____Wheaton Franciscan Healthcare - Franklin
____Midwest Orthopedic Specialty Hospital

**Date Initiated: _____ Individual Completing Form _____Phone Number _____**

**Authorization Number** (if provided by MD Office**): _____**

**Diagnosis:** _____

**Rationale to support Same day or Additional Testing**: _____

_____

_____

_____

**Procedure Name:** _____ **CPT CODE if available** _____

**Service Date:** _____

**Radiologist Name:** _____
(First and Last Name)

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