FOR MORE THAN 30 YEARS

Hospital Access Management™

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

April 2014: Vol. 33, No. 4
Pages 37-48

IN THIS ISSUE

AHC Media

Hospital cuts denials by 63% despite a surge in payers

More stringent requirements for auths means revamped processes needed

Patient access areas are seeing more procedures requiring authorization, a surge in the number of insured patients, and more clinical requirements from payers. All of these factors make an increase in claims denials — and much lost reimbursement — very likely.

"Without an educated and focused staff, lost revenue to the tune of tens of thousands of dollars can occur," warns **Leigh A. Hunt**, patient access manager for ambulatory services and the Patient Access Center at UK HealthCare in Lexington, KY.

Some payers now require a mid-level provider to do a peer-to-peer review before authorizing costly diagnostic tests such as stress echocardiograms, exercise cardiolites, and invasive procedures such as catheterizations and pacemaker/defibrillator implants, reports **David Hoogenboom**, CHAA, team lead/patient access liaison III at the Outpatient Access Department at Danbury (CT) Hospital. *(See related stories on new requirements for clinical information, p. 39.)*

Despite this requirement and other more stringent ones, Danbury Hospital's claims denials decreased by 63% between 2011 and 2013. One reason is the department's a double-check process, which ensures that peer-to-peers are completed. "Staff notify both the financial department that is responsible for obtaining the authorization and the doctor's office," says Hoogenboom.

If the patient is added on and needs to have their test the same day, it's often challenging to find a provider to take time out to do the peer-to-peer review. If this step is not completed prior to the service being rendered, a claim denial might result.

"The double-check process ensures that everyone is aware," says Hoogenboom. "The two departments can collaborate on a timeline for the peer-to-peer."

Over the past year, reports Hunt, "we have noticed a downward trend in our overall denials for registration categories by as much as 15%. We look forward to continue trending this number down." UK HealthCare's patient access leaders reduced denials with these processes:

• UK HealthCare's patient access center has a staff of 21 customer access associates who provide a detailed pre-screening for patients.

"An empowered and knowledgeable access staff is one of the best lines of defense against claim denials," says Hunt.

About 80% of ambulatory patients are pre-registered. They review these accounts for insurance, as well as correct demographic information, for each patient scheduled to come into the clinic, says Hunt. This process typically is done two days out from the appointment, so patient access staff can reach patients if there is any type of problem and enlist their help if needed.

• An accuracy audit is performed monthly on each pre-registration associate.

All items that could cause a claim denial are checked. "This ties directly into our performance evaluation criteria and monthly performance meetings," says Hunt.

• Patient access managers make sure each scheduling and registration agent is equipped with current and complete information on payer requirements.

"As we know, insurance plans are dynamic and ever-changing," says Hunt. "We, as managers, have to ensure that our staff who are dealing with these plans every day are as educated as possible."

Don't assume eligibility is unchanged

John Porter Jr., access denial analyst at Scripps Health in San Diego recently warned his staff that even information on file from even a week ago might be outdated.

"Some patients' eligibility changed three times in a three-month span," he says. "Keeping up with that has been hard on everyone."

Eligibility changes were a major challenge at the start of the new year, reports Porter. The expansion of Medi-Cal, California's Medicaid program, caused certain patients with local plans to be transitioned into Medi-Cal HMOs. "Many of these patients were not fully aware of the impact this had on their access to certain providers," says Porter.

These patients, and patients who purchased cov-

EXECUTIVE SUMMARY

Despite a growing trend of more stringent payer requirements, Danbury (CT) Hospital's claims denials decreased by 63% between 2011 and 2013. UK HealthCare in Lexington, KY, has seen a downward trend in denials by as much as 15%.

- To comply with peer-to-peer review requirements, have staff notify the financial department and the doctor's offices.
- Remind staff that information on file from even a week ago might be outdated.
- Have the revenue integrity group notify patient access staff if additional procedures require authorization.

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media, LLC, One Atlanta Plaza, 950 East Paces Ferry Road, Suite 2850, Atlanta, GA 30326. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 550669, Atlanta, GA 30355.

SUBSCRIBER INFORMATION

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

Subscription rates: U.S.A., Print: 1 year (12 issues), $429. Add $19.99 for shipping & handling. Online only, single user: 1 year, $379. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

Editor: **Stacey Kusterbeck**, (631) 425-9760.
Executive Editor: **Joy Daughtery Dickinson** (404) 262-5410 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey.**
Director of Continuing Education and Editorial: **Lee Landenberger**

AHC Media

Editorial Questions
For questions or comments, call Joy Dickinson at (404) 262-5410.

erage on the Health Insurance Marketplace "can very easily end up attempting to access care outside of their network of approved providers," says Porter.

Verifying eligibility at every encounter is a central focus "to limit patients that have gone astray," says Porter. "When staff locate a patient out of their network, staff educate and redirect the patient as appropriate."

Requirements change often

The new exchange plans are another factor that could result in more denials, says Hoogenboom. Staff must now learn the methods for eligibility verification, how to look up a patient's benefits, and which services require authorization, for many more plans.

"If these steps are not followed and this information not learned, denials will definitely occur," says Hoogenboom.

The University of Tennessee Medical Center in Knoxville is seeing payer requirements change several times a year, says **Sharon Bright**, manager of patient access. "This is one of the main reasons for claims denials," she says. "To prevent the denials, we have to stay educated, updated and informed."

One way Bright handles this education is by signing up for insurance newsletters. She then sends a periodic email with updates to physicians' office managers. "The most important things to know are the precert requirements for each plan and how to access their websites to get information," Bright says.

Just because one particular insurer doesn't require authorization for a particular test doesn't mean that it won't soon require it. Hoogenboom says, "Keeping an accurate list of services that require authorization, and updating it regularly, is a necessity." *(See related story on improving relationships with payer reps, p. 40.)*

SOURCES

For more information on preventing claims denials, contact:
- **David Hoogenboom**, CHAA, Team Lead/Patient Access Liaison III, Outpatient Access Department, Danbury (CT) Hospital. Phone: (203) 739-8200. Email: david.hoogenboom@wcthn.org.
- **Leigh A. Hunt**, Patient Access Manager, Ambulatory Services/Patient Access Center, UK HealthCare, Lexington, KY. Phone: (859) 323-3001. Fax: (859) 323-2021. Email: leigh.bobo@uky.edu.
- **John Porter Jr.**, Access Denial Analyst, Scripps Health, San Diego. Phone: (858) 657-4048. Fax: (858) 587-4499. Email: porter.john@scrippshealth.org. ■

Clinical information coming into play

Payers are looking at medical necessity

Patient access managers at UK HealthCare in Lexington, KY, are seeing a trend in more stringent referral requirements with a clinical focus. For example, a patient's primary care physician has to be much more involved in coordinating the specialty care of their patients.

"This is particularly true of our Kentucky Medicaid managed care organization plans," says **Leigh A. Hunt**, patient access manager for ambulatory services and the Patient Access Center at UK HealthCare in Lexington, KY.

One of the main areas the outpatient access department at Danbury (CT) Hospital performs preregistration for is cardiology testing. "We clear an average of 55 to 75 patient accounts daily for echocardiography, nuclear stress testing, regular treadmill stress testing, cardiac rehab, and arrhythmia clinic patients," reports **David Hoogenboom**, CHAA, team lead/patient access liaison III.

Hoogenboom recently received training on clearing these accounts, in order to be a back-up for the person who is normally responsible for this. "Since then, I have learned so much about the various kinds of tests, as well as Medicare, Medicaid, and commercial insurers," says Hoogenboom. "I am proud of the record we have in our department. We have very few denials."

Extra steps needed

Because Medicare requires services rendered to be medically necessary for claims to be paid, patient access staff members need access to patients' clinical information in the electronic medical record.

"Each service scheduled must have appropriate ICD-9 diagnosis codes, to verify that the service is medically necessary," says Hoogenboom.

In addition, many insurance companies use third-party medical management companies to approve or deny services. "Staff must be properly trained on how to access these resources," he says. "Building a depth of knowledge of CPT codes must be done as well."

Each day, Danbury Hospital's patient access staff send an email to the revenue integrity group on which procedures are scheduled for that day in the cardiac catheterization lab and whether or not these require authorization. "The following morning, another

email is sent back to us letting us know if there were any additional procedures that the performing doctor decided to do while performing the original procedure," says Hoogenboom.

The needed for additional procedures, such as angioplasties, stent placements, and ablations often is not apparent until the original procedure is in progress. "The email informs us that we now need to make another call to see if the additional procedure requires authorization," says Hoogenboom. "We then notify the ordering doctor to obtain it, if necessary." ■

Establish rapport with payer reps

It keeps you current with changes

Patient access managers must stay in contact with their assigned provider representatives and establish a good working relationship with these individuals, urges **Leigh A. Hunt**, patient access manager for ambulatory services and the Patient Access Center at UK HealthCare in Lexington, KY.

"They can be an invaluable resource in helping research and reduce claims denials," says Hunt. "They are the experts about their plans and have been involved in the contract set up for our enterprise."

For each plan, says Hunt, patient access areas need a "high-level understanding" of the plan's unique requirements for referral and pre-certification. "Study what causes certain plans to deny claims," she recommends. "Become vigilant in reviewing denial reports and knowing what causes a particular plan to deny. This will be different for each company."

The best approach is for patient access to have a good contact at each insurance company, says **David Hoogenboom**, CHAA, team lead/patient access liaison III at outpatient access department at Danbury (CT) Hospital. This approach allows the contacts to disseminate new information to staff in a more timely manner, Hoogenboom says. "Preventing denials requires accurate and complete fact-finding on the part of patient access," he says. "Much of this information will come from contacting an insurance company." These questions must be asked:

1. Is the patient's coverage active and will it be active on the scheduled date of service?
2. Is the hospital in-network with the patient's plan? "Some plans, including some EPO [exclusive provider organization] plans, have no out-of-network benefits," notes Hoogenboom.
3. Is a referral required from the patient's primary care doctor?
4. Is an authorization required for the ordered procedure?
5. Does the patient have a copay for the service? Does their plan have a deductible? If so, how much has been met?

"As a new initiative, we try to collect at least a portion of deductibles at the time of service," reports Hoogenboom.

All of this information needs to be recorded in the patient's account with the insurance representative's name and a reference number for the call. This information is very important in the case of a denial, says Hoogenboom. When appealing the payer's decision, the denial can be contested with documentation of the information that a particular insurance representative provided.

"By following these steps, denials can be prevented — and when they do occur, successfully appealed," says Hoogenboom. ■

How you can address price-shopping patients

Offer help before patients ask

"How much will it cost me?" seems like a simple enough question to patients, but patient access employees know it can quickly get complicated.

"We are seeing more patients ask for our costs. With higher out-of-pocket responsibilities, this is very important for patients to be aware of prior to having the service," says **Terri Miles**, patient access manager at Wheaton Franciscan Healthcare in Glendale, WI.

If a patient has a high out-of-pocket cost, Wheaton Franciscan Healthcare's registrars don't wait for the patient to ask if help is available. They ask the patient right away if the amount will create a financial hardship. "If so, we get them to a financial counselor," says Miles. The financial counselor starts working right away on assisting the patient with possible government programs that might be available or setting up a payment plan.

The biggest challenge when giving price quotes, says Miles, is that patients often are completely unaware of their benefit levels. "Staff provide patients with a self-pay estimate, or if they are willing to provide their insurance information, we can make it specific to their carrier and any contractual details that might come into play," says Miles.

Patient access staff members use an online tool to supply price quotes to patients (Emeryville, CA-based MedeAnalytics). "For services that are not yet scheduled, we require a CPT code," says Miles. "There is much variation, and we'd like that shopping quote to be fairly close in reflecting the service to be provided."

Sticker shock alleviated

At Cape Coral (FL) Hospital, patients aren't the only ones requesting estimates.

"We are also seeing staff from provider's offices calling to get estimates on behalf of the patient," says **Jamie Bruner**, manager of registration services. "In our region, we have a large self-pay population."

Patients are better informed with price information, "alleviating sticker shock on the day of their service," says Bruner. "It makes the check-in process smoother for both the registrar and the patient."

Prices for most diagnostic services can be found on the hospital's website, but prices for surgical procedures are "much more complex," says Bruner. Even if two surgery services are classified as the same procedure, prices might vary depending on the level of care given at the time of service. "Because of this, staff avoid telling a patient that the quote they are being given is a final price," says Bruner. Staff members are trained to inform patients:

- that the prices they are quoting are estimated prices only;
- that any additional procedures, tests, supplies, medications, and or ancillary services utilized or performed per their physician's request would be additional charges to be included on the final hospital bill.

Designated individuals in the admitting department are responsible for educating patients about cost. "These reps are identified by their leadership as top performers," says Bruner. "They are promoted from a selection of highly skilled registrars who apply for these positions."

Once promoted, the reps are trained by patient access managers on quoting difficult estimates and financial screening. They also inform potential patients about discount programs for the uninsured, self-pay deposit requirements, and installment payment arrangement options.

"All these efforts are geared toward making the process easier for the patient, in hopes that they see us as a provider of choice," says Bruner. *(See related stories on online estimates, below, and how customer service skills can affect a patient's decision, p. 42.)*

SOURCES

For more information on providing price quotes to patients, contact:

- **Jamie Bruner**, Manager, Registration Services, Cape Coral (FL) Hospital. Phone: (239) 424-2659. Fax: (239) 424-4075. Email: Jamie.Bruner@LeeMemorial.org.
- **Terri Miles**, Manager, Patient Access, Wheaton Franciscan Healthcare, Glendale, WI. Phone: (414) 447-2610. Fax: (414) 447-2768. Email: Terri.Miles@wfhc.org.
- **Susan Smith**, CHAA, Benefit Representative, Patient Access, Cox Medical Center Branson (MO). Phone: (417) 348-8940. Fax: (417) 348-8029. Email: Susan.Smith4@coxhealth.com. ■

EXECUTIVE SUMMARY

Patient access departments are offering financial counseling and online price estimates to patients who call with questions about cost. Staff members from provider's offices also are calling to get estimates on behalf of patients.

- Ask patients directly if high out-of-pocket costs will create a financial hardship.
- Remind staff that prices can vary depending on the level of care given at the time of service.
- Designate top-performers in the admitting department to assist patients inquiring about cost.

Patients create their own estimates

Patients at Danville, PA-based Geisinger Health System can create their own estimates online via a self-serve portal, MyEstimate.

"This provides patients with out-of-pocket estimates on nearly 300 services," says **Barbara Tapscott**, vice president of revenue management.

After patients enter their insurance information, estimates are tailored to the verified benefit coverage and the location of the service requested. Patients can select a hospital, a hospital-based clinic, a physician's office, or an ambulatory surgery center for their estimate.

"The Geisinger product provides a combined estimate, in that it includes hospital and physician expenses," says Tapscott. Because the patient's insurance is verified, the estimate takes into consideration negotiated insurance rates rather than gross charges. If the patient is uninsured, or if a service is unlisted, MyEstimate directs the patient to a financial counselor. The counselor can be accessed by a toll-free number, by creating an online request, or by visiting a Geisinger location.

"Financial counselors can assist uninsured patients with alternative funding options, such as state pro-

gram enrollment," adds Tapscott. ■

Cost is not only factor in choice

Let patients know they'll be well-cared for

When prospective patients call to ask about cost, **Susan Smith**, CHAA, a benefit representative for patient access at Cox Medical Center Branson (MO), not only does everything in her power to give the best information she possibly can. "I also promote the additional advantages and experience that our facility has to offer," she says.

Smith does the following:

• She "upsells" the involved department.

"The patient needs to understand they will be well taken care of while at our facility," says Smith.

She regularly checks with outpatient service departments about the combined years of experience of that particular department. Then, she shares those specifics with patients. "I explain that we have long-term technicians who take pride in their jobs and care about their patient," says Smith.

She adds that technicians are constantly receiving patient feedback on how comfortable they make patients feel and the level of professionalism displayed. "I let the patient know that a technician will be happy to talk them through their procedure, and answer any procedural questions they may have," says Smith.

• She lets patients know that their time is valued.

Smith explains that anyone waiting past their scheduled time is encouraged to let front desk staff know. "Our staff will check for any situation that is causing a delay," she says.

For example, there are times when a "difficult draw" in another area of the hospital requires a lab technician, which results in a longer wait for lab patients. Likewise, an emergency scan can disrupt the scheduled patients' timeframes.

In these cases, says Smith, "our registrars inform the patients and let them know the expected wait time expected. We also let the patients know they can reschedule if they need to do so."

Always thank patient

Terri Miles, patient access manager at Wheaton Franciscan Healthcare in Glendale, WI, says, "While we can't guarantee we won't lose a patient to a competitor if all they are considering is the cost, we still treat every inquiry following our 'always' behaviors."

These "always" behaviors are expected from staff: Smiling, making eye contact, greeting the patient, introducing yourself, communicating clearly, and verifying there is nothing else the patient needs when the process is completed.

Staff end every call by thanking the patient. "We are patient and courteous in that interaction," says Miles. "In no way does that caller get the feeling that their question to us was an inconvenience or bother." ■

Extra steps needed for 'exchange' plans

Time-consuming calls to payers necessary

Some patients who obtained "exchange" plans on the Health Insurance Marketplace are presenting to registration areas, with no proof of having done so.

"We are seeing some patients that do not have their insurance card because they haven't received it. It's hard to identify that they actually have the coverage," says **Tracy Bonnell**, director of revenue cycle at St. Anthony's Medical Center in St. Louis, MO.

In some cases, patients whose coverage became effective several weeks earlier still are waiting to receive an insurance card. "We were surprised that patients wouldn't have access to an insurance card more quickly," says Bonnell. "We then do additional research to obtain the benefit coverage."

Staff members typically verify coverage with a real-time eligibility system, used for about 80% of payers. "Our system allows us to apply the patient's coinsurance deductible amounts and give them an estimate based off the particular plan," she says. However, the exchange plans are not yet in the system, and information on the exchange plans typically is not available from payer websites.

This issue means staff members need to call the payer to attempt to obtain the patient's ID number and eligibility information. "We typically call the health exchange directly, which we struggle with because of the hold times," Bonnell says.

Patients aren't turned away

Patients on exchange plans are in some cases presenting for services believing they are insured, when their coverage has not yet become effective.

"In that situation, it's a challenge to verify coverage. We are not turning any of those members away," says **Angad S. Buttar**, MHA, senior manager of revenue cycle operations for Kaiser Permanente's Mid-Atlantic States Region in Rockville, MD.

Buttar advises patient access leaders to first ask registrars what questions they're hearing from patients regarding exchange plans, and then provide staff with scripting to answer those specific questions. "Being proactive is the only way to go here," Buttar says. "Someone may not have answered a question effectively. But the next time a patient comes in with the same question, we can be sure to knock it out of the park."

These are the two most common questions registrars have fielded:

- "I signed up online. Can you confirm my coverage?" For this request, registrars refer the patient to the member services department.
- "What amount do I owe, in addition to my premium?" "Once we receive the appropriate eligibility and coverage information, we will bill these members, if necessary, for any co-pays or other cost share they owe for the services provided," says Buttar. Registrars do not collect cost shares, deposits or co-pays from individuals who state they have coverage which is not currently showing up in the system, he explains.

Patient access employees aren't always able to answer a patient's question, sometimes because limited information is available about the exchange plan. "The first thing is for registrars to understand their own limitations," Buttar says. "If you don't know a policy's effective date, what information do you know that can help the person out?"

If the question can't be answered, says Buttar, "there may be an internal resource within the organization that could assist the patient," he says.

The registrar might be able to get the answer by calling the payer, or by putting the patient in touch with an insurance verification specialist. Similarly, patient access leaders can network with peers at nearby facilities to share information on exchange plans.

"Talk to other hospitals or physician groups in the region, and ask them about what they are seeing," Buttar advises. "Keep that communication open."

EXECUTIVE SUMMARY

Patient access departments are seeing patients who purchased "exchange" plans on the Health Insurance Marketplace presenting without proof of coverage.

- Staff must contact the payer to obtain the patient's ID number and eligibility information.
- Patients don't always realize their coverage isn't effective yet.
- Registrars need scripting to answer questions from patients regarding exchange plans.

SOURCES

For more information on patients presenting with exchange plans, contact:

- **Tracy Bonnell**, Director of Revenue Cycle, St. Anthony's Medical Center, St. Louis, MO. Email: tracy.bonnell@samcstl.org.
- **Angad S. Buttar**, MHA, Senior Manager, Revenue Cycle Operations, Kaiser Permanente Mid-Atlantic States Region, Rockville, MD. Phone: (301) 816-6448. Fax: (301) 388-1743. Email: angad.s.buttar@kp.org. ■

E-learning: 4,800 hours of coverage costs saved

Fewer hours of classroom training needed

On a regular basis, patient access managers at Minneapolis-based Hennepin County Medical Center had to provide coverage for staff members pulled out of the department to attend eight to 16 hours of classroom instruction.

Doing so was stressful for managers and costly for the department, says **Steve Nilson**, MEd, CRCR, project manager for revenue enhancement. "It was very difficult, because you had to pay floats to provide coverage," he says.

After e-learning modules were developed, less classroom training was needed. With 400 patient access employees no longer attending an average of about 10 classroom hours of training, e-learning resulted in a significant cost savings. "The cost saving was mostly the salary of clinic coverage," says Nilson. "Putting a dollar figure on it is a little hard because staff salaries can vary, but at $20 dollars an hour, the savings would be $96,000."

Newly implemented monthly webinars have successfully reviewed important information on the registration process at OSF Healthcare in Peoria, IL, says **Jessica Atkinson**, a patient access services representative III. "It enables us to have a meeting environment without having to physically be together," Atkinson says. "Since various webinar times are offered, it has allowed us to get almost everybody's participation."

A question-and-answer session is offered after each webinar, and answers are posted so that later webinar participants can see the responses. A summary is distributed, so anyone unable to attend can

keep it for future reference. "Somebody else may have had the same question, and they just didn't ask it," Atkinson says.

"Because different departments do different things, some sites may see certain things less often, or not at all, in comparison to other sites," she says. A recent webinar reviewed organ transplant processes, for example.

While many patient access employees enjoy receiving information via webinars, others prefer to receive it in person. "If something is brand-new or complex material, we give the option for both," says Atkinson. When trainers presented a recent webinar on the Affordable Care Act, some staff chose to attend in person.

"Some people were in the same building, so it made sense for them to sit in the conference room," she says. Atkinson herself was out of town when there was bad weather, so she watched the webinar remotely.

The webinars save money on traveling expenses and food and drink that previously was ordered for large group training sessions held in conference rooms.

"We also cut down on overtime, because we don't have to make sure anyone's hours are covered to allow them to attend a meeting," says Atkinson.

15 minutes or less

Although nine e-learning modules are available for patient access employees at Hennepin County Medical Center to view at any time, they're cautioned not to watch them all at once.

"We recommended that no one sit down and watch all of them in a row, which would end up being two and a half hours," says Nilson.

Retention of knowledge is much greater when staff members receive information in short "bursts" of 15 minutes or less, he says. Staff members can access this education at the beginning of their shifts or during downtimes.

The modules range from 15 to 20 minutes, but future modules might be as short as 10 minutes. "When we redo the program, we will work hard to get them even shorter," explains Nilson.

Nilson emphasizes that the department uses e-learning only for refreshers. "It's a great way to give tips and tricks and reminders," he says. "But I wouldn't ever recommend it for the new employee who knows nothing about our system."

New hires still attend a four-day instructor-led class. "We still feel that is the best way to deliver brand new knowledge," says Nilson.

Two trainers wrote scripts for the e-learning modules. These were approved by a review committee with representation from patient access services, the emergency department registration, admitting, and ambulatory services. "We went line by line to make sure all the information was accurate," says Nilson. Once the script was approved, the trainers developed the e-learnings.

The nine modules now can be updated as needed. "We put a lot of time and effort in developing them," he says. "Moving forward, we have a nice foundation, so the build for next year's refresher will be much smaller."

The plan is to add two or three modules each year. Future modules will cover complex patients, auto accidents, worker's compensation, and patients who are wards of the state. "With our next run, we will expand it to the patients that you don't see as often," he says.

Modules are especially helpful when quarterly audits, which are done on all access staff, identify areas where someone is struggling.

"Rather than sending someone to a whole day training class, the online module can help them bridge the knowledge gap they are missing," says Nilson. "If that doesn't work, we can escalate it to full-day training. *(See related stories on how e-learning allowed trainers to be reallocated, p. 45, and how one department plans to improve its e-learning modules, p. 46.)*

EXECUTIVE SUMMARY

By developing e-learning modules, patient access areas at Hennepin County Medical Center in Minneapolis save an estimated $96,000 annually on coverage costs. Other departments report cost savings on traveling expenses and food and drink.

- Trainers can be pulled from classroom settings to work one-on-one with staff.
- Staff can access modules before shifts or during downtime.
- Retention is best with modules of 15 minutes or less.

SOURCES

For more information on online training in patient access areas, contact:

- **Jessica Atkinson**, Patient Access Services Representative III, OSF Healthcare, Peoria, IL. Phone: (309) 683-4360. Fax: (309) 683-4786. Email: Jessica.N.Atkinson@osfhealthcare.org.
- **Steve Nilson**, MEd, CRCR, Project Manager, Revenue Enhancement, Hennepin County Medical Center, Minneapolis. Phone: (612) 873-2483. Email: Stephen.Nilson@hcmed.org.

• **Diane Ward**, Assistant Director, Enterprise Patient Access Services, UK Healthcare, Lexington. Phone: (859) 323-2590. Fax: (859) 218-7526. Email: diane.ward@uky.edu. ■

Two extra hours to 'shadow' staff

Trainers reallocated from classroom

In 2013, patient access leaders at UK Healthcare were seeking to maximize their training resources.

"We don't have a big training team. We have to make sure that we offer training that is effective and has the best ROI," explains **Diane Ward**, assistant director of admitting and registration.

In 2014, online training modules were developed for insurance terminology, establishing guarantor guidelines, and copay collection. "We just started to roll this out, but we are really excited about it," says Ward.

The modules help trainers to cover all the elements that have to be captured and verified at registration. "You need to meet both clinical and financial needs," Ward says. "Training has become very complex."

The online modules break up a large amount of material into smaller pieces so registrars can "soak up the information more easily," she says.

Because trainers are salaried, there were no direct cost savings resulting from online training. However, it allowed trainers to be reallocated from the classroom setting. "This is where we were looking for a gain, in moving to online training," says Ward. "We've started small with the subjects offered online, but already, we've been able reduce our classroom training by two hours."

Basics covered online

Previously, trainers had to cover all of the necessary material in the classroom setting — even basic insurance terminology.

"We found we were spending a lot of time in the classroom covering the basics and not focusing on the more difficult issues, such as MSPQ [Medicare as Secondary Payer]" says Ward.

Staff members are now expected to cover the basics themselves with the online modules. This approach frees up trainers to conduct focused audits and to work alongside individual staff members as they register patients. "By shadowing, that's when we figure those pieces that they may have missed in the classroom," says Ward. "When the trainer is right there next to them, it sticks with them." The personal attention has helped staff to master these challenging aspects of registration:

• Medicare patients who are dual-eligible.

Trainers help registrars to ask the right questions to obtain the information that is needed.

"You can practice in the classroom, but you never know what the patient is going to say when they are in front of you," says Ward. "Staff need to be able to weed through the information the patient is providing."

• Interpretation of data that payers send regarding insurance eligibility.

"Payers aren't very consistent in what they send back," Ward explains. "When you get in the real-world setting and you have hundreds of different plans, it can be overwhelming." This situation prompts a lot of questions that wouldn't come up in the classroom, which trainers then address on the spot.

• Application of what staff learned in the classroom on system functionality to actual patients.

"We have an added layer of complexity in that we have two registration systems," notes Ward. "This prompts questions, when staff try to apply insurance know-how and plug information into the system."

Jump in accuracy

Right after staff at Minneapolis-based Hennepin County Medical Center began using e-learning modules, "we saw a fairly decent jump in our registration accuracy, of about 2 to 3%," reports **Steve Nilson**, MEd, CRCR, project manager for revenue enhancement.

Employees were required to take two tests after the e-learning modules and to pass each with a score of 80 or above. The first was a 50-question multiple-choice exam completed online. Staff members received immediate feedback on their mistakes, and they were required to keep taking the test until they passed. "I think that it was a helpful tool to let them know where they were struggling and that they had to go back and learn it before they retook the test," says Nilson.

While scoring the second exam — a two-hour skills test — the proctor discussed any errors that were made with the test-taker.

Being able to ask questions of the proctor was "amazingly helpful," says Nilson. "Everyone got one-on-one training, specifically designed for the things they were falling down on." ■

Successful `first run' at e-learning

Modules will be tweaked, updated

In 2014, nine e-training modules were created for patient access employees at Minneapolis-based Hennepin County Medical Center. These modules cover registration, scheduling, real-time eligibility responses for electronic verification, coverage termination, dependents, medical assistance, Medicare patients, Medicare as Secondary Payer Questionnaire, and in-house discount and self-pay programs for admission and treatment.

"We pinpointed some of the biggest issues we were seeing with registration accuracy and claims denials," says **Steve Nilson**, MEd, CRCR, project manager for revenue enhancement. "This was our first run at it. There are lots of things we can tweak and do better."

The department has seen many benefits from the e-training, "but we also had some difficulties," reports Nilson. Here are some examples:

• Some registration areas didn't have headphones.

Although the modules gave employees the option of using closed captioning instead of audio, "this was unfortunately lost on some people," says Nilson. Some watched the video without sound, and therefore, were unable to follow the interactive commands.

To resolve the problem, the training department lent out headphones to various departments to use specifically for e-learning.

• Some employees had trouble using the modules because they weren't computer-savvy.

"We have people who struggled with just the computer functionality, which happens anytime you are using technology," Nilson says.

Part of the e-training was cut off for some users, because screen sizes varied. "A savvy user would know they just needed to zoom out, but for others, it was a struggle," he says. To address this, a module was developed on how to use the e-trainings, such as how to pause and fast forward.

• Screens appeared different from those used by some registration areas.

"Not everyone follows the exact same work flow," says Nilson. "They see the same registration screen at the end, but how they get to that screen might be very different."

Disclaimers were placed on the screens stating "This is just one way to access a patient record." "We weren't trying to teach people how to open up a record; that was assumed knowledge," explains Nilson.

The purpose of the module was to instruct users how to register a patient after accessing the record, he explains. Still, some employees became confused when the screen appeared differently than what they were accustomed to viewing.

Future modules will be changed so that employees can select the type of user they are on the first screen, so they view exactly the same screens that are used in their particular registration area. This change will get people to "buy in" right at the beginning, he says, instead of tuning out when they see screens that don't look familiar.

"If you choose the ED, it might start you on the tracking board. If you choose clinic staff, it might start you on the daily appointments report," says Nilson. ■

CMS' two-midnight rule: Who must sign off?

The Centers for Medicare and Medicaid Services (CMS) announced a clarification to the "two-midnight rule" that a physician must sign off on the admitting paperwork for Medicare beneficiaries, according to the National Association of Healthcare Access Management (NAHAM).

CMS published the two-midnight policy in an effort to explain when a Medicare beneficiary might qualify for overnight care versus outpatient care. This distinction is important to hospitals because the payment to the hospital is higher for overnight stays than for outpatient care. The rule initially established that a physician must have good reason to believe that a patient will require two nights in the hospital to qualify for the higher hospital rate from Medicare.

The clarification requires physicians to sign off on the admitting paperwork for Medicare beneficiaries before the patient is discharged. By signing the admitting paperwork, the physicians are accepting responsibility for the determination that there is good reason the patient will require two nights in the hospital. Medicare's recovery auditors will not audit inpatient claims under the two-midnight rule until after Sept. 30, 2014.

A hospital still might comply with the regulation if a non-physician staffer writes the admitting order into the medical record, even if the recording staffer does not have the independent authority to admit a patient. However, in all cases, the physician must sign the admitting paperwork prior to the patient's release.

For example, a hospital will be in compliance with the regulation if a nurse documents a physi-

cian's verbal order to admit a patient in the medical record if the physician signs the decision before the patient leaves the hospital. Similarly, residents, physician assistants, and nurse practitioners may write the inpatient admitting order as a proxy for a physician so long as the physician signs the order before the patient is discharged. In every case the physician's signature represents that she approves and accepts responsibility for the admission decision.

Hospitals still may be compensated in cases when a doctor later refuses to sign the admitting order. However, they will be compensated at outpatient rates. The hospitals must send the bills through Medicare's Part B system for outpatient care.

CMS' two-midnight policy can be found at http://go.cms.gov/19SMvu8. ■

`Balance billing' leaves patients shocked

In emergent situations, paperwork is often the last thing on a patient's mind.

Patients that have the wherewithal to remember to choose an in-network hospital to avoid large bills for treatment assume that they may be treated by any physician in the hospital and their insurance will cover the treatment. Unfortunately, many find out this situation is not true several weeks later with the arrival of a hefty "balance bill," according to the National Association of Healthcare Access Management (NAHAM).

Balance billing is a common practice that bills the patient for the remainder of the cost of treatment that the insurance refused to pay because the treating physicians were out-of-network, even though they practice at a hospital that was in-network.

These unexpected bills can have huge consequences on patients and their families. NBC 5 in Dallas recently ran a story about Melinda Allen, a patient at a local emergency department. Allen woke up on a Saturday with intense abdominal pain. She had her husband take her to a hospital she knew was in-network. Several tests later, Allen was diagnosed with an ovarian tumor large enough to require surgery.

The billing was less straightforward than her treatment plan. Allen paid nearly $5,000 out-of-pocket for her treatment, in addition to her $1,500 monthly premium. Allen assumed her insurance would cover the rest since she was treated at an in-network hospital. Allen was shocked when she later received a bill for nearly $700.

The amount of the bill Allen received was the balance left over from the price of the treatment charged by the emergency department doctor and the price her insurance company thought was appropriate.

Patients must sort it out

This practice leaves the patient to sort out the claim with their insurance company.

"People are really vulnerable when they go into an emergency room," **Stacey Pogue** of the Center for Public Policy Priorities explained. "It's unfortunate, again, that we're put in that position because insurance companies and doctors can't decide what is appropriate reimbursement."

In situations such as Allen's, where does the blame fall? Allen chose an in-network hospital. Physicians, by law, are not allowed to ask about insurance and must treat all patients regardless of their ability to pay. NAHAM asks: Should the intake process include a list of in-network and out-of-network physicians? ■

NAHAM to hold annual conference

In May, the National Association of Healthcare Access Management (NAHAM) Annual Conference & Exposition will celebrate its 40th year. The conference will be held May 13-16 in Hollywood, FL.

At past conferences, the education was built around what the job was then known as: admitting. Now, NAHAM and its annual conference represent the accredited, knowledge-based profession of patient access services, which encompasses a multitude of processes to patients and healthcare facilities and serves as the front-end of the revenue cycle. According to NAHAM, the conference will offer the opportunity to exchange ideas, share information, learn from experts in the field, and network with colleagues.

The speaker for the opening general session is Jake Poore. For the past 11 years, Jake and his team at Integrated Loyalty Systems have helped many healthcare organizations make cultural transformations, including University of Chicago Hospitals; Penn Medicine in Philadelphia; Ochsner Health System in New Orleans; MedStar Visiting Nurses in Maryland, District of Columbia, and Virginia; and National Rehabilitation Hospital in Washing-

ton, DC. In addition, Integrated Loyal Systems has contributed to creating patient-centric blueprints for organizations such as the University of Colorado Hospitals in Aurora; Jersey Shore University Medical Center in Neptune, NJ; and BJC Healthcare's Progress West Hospital in O'Fallon, MO.

Also at the conference, Joint Commission Resources will present on the history of the organization, the survey process for The Joint Commission and the Centers for Medicare and Medicaid Services (CMS), and patient access services' role in the successful completion of the surveys. Participants also will learn about the new NAHAM Joint Commission Survey Toolkit and the CMS Survey Toolkit.

The closing general session will bring together NAHAM's experienced leaders — both of the association and at their facilities — to present on leadership and what it means in the field of patient access. From conceptual applications to hard data to case studies of leadership growth implementation at facilities, this presentation will touch on a wide variety of practical leadership tools. The panelists will be:

- Jeff Brossard, CHAM, patient access director, Mercy Hospital – Springfield (MO) and NAHAM immediate past president;
- Elizabeth Reason, CHAM, director of patient access/pre services at Cleveland County HealthCare System in Shelby, NC, and NAHAM certification commission chair;
- Brenda Sauer, CHAM, director at New York Presbyterian Hospital, New York, NY, and NAHAM president;
- Lisa Woods, CHAM, manager of operations at WellSpan Health, York, PA.

For details and online registration, visit www.naham.org/conference. For more information, email info@naham.org or call (202) 367-1125.

Future NAHAM conference dates and sites are April 19-22, 2015, in Indianapolis, IN, and May 24-27, 2016, in New Orleans, LA. ■

COMING IN FUTURE MONTHS

- Must-have skills to look for in patient access hires
- Use preceptors to boost retention at no extra cost
- Dramatically increase collections for high-deductible plans
- Proven ways to meet payers' new clinical requirements