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AHC Media

Stop surge of denied claims due to payers' new clinical requirements

Obtaining auths 'can feel like a trial'

Payers are asking for much more detailed clinical information and questioning the reasoning behind decisions made by providers, before giving authorization for costly diagnostic tests, report patient access leaders.

"Payers are performing a comprehensive clinical review for many service lines, including advanced imaging and cardiology," says **Michael Prazniak**, assistant director of pre-access, patient access, and patient financial services operations at Florida Hospital in Orlando.

Commercial payers are requiring "more and more" clinical information to support the doctor's decision to order a specific test, says **David Hoogenboom**, CHAA, team lead/patient access liaison III in the Outpatient Access Department at Danbury (CT) Hospital. Here are recent trends in payer requirements:

• More payers are requesting peer-to-peer reviews for advanced imaging areas, particularly oncological positron emission tomography (PET) scans.

"In addition to a more in-depth clinical review, the sheer volume of services and number of payers that now require authorization for those services has increased," Prazniak says.

Medicaid requirements for prior review for imaging have significantly increased the authorization team's workload. "Trends seem to be fairly consistent based on which peer review organization the payer employs to perform clinical assessment, when applicable, as opposed to the individual payer itself," Prazniak adds.

• Payers are no longer satisfied with recent clinical progress notes.

"We are now seeing more requests for lab and lower-level imaging results, past treatment plans including several months of therapy or pharmaceutical interventions, EEG and EKG readings," says Prazniak.

• Payers are reviewing more closely what objectives will be satisfied by the test for which the authorization is being requested.

Payers often suggest alternative services after their clinical review and communicate with physicians about possibly altering the test being ordered, says

Prazniak. For example, if a provider orders a CT scan with and without contrast, a payer might suggest it be done with contrast only.

• Payers are suggesting patients go to preferred facilities for testing.

"Payers are now steering patients to their preferred freestanding facilities, after we have been able to receive a clinical approval for a test based on medical necessity," says Prazniak. This step has increased the number of cancellations the department is experiencing, he adds.

• Lab-based sleep studies are receiving much more scrutiny.

"More and more payers are authorizing home-based studies as the first diagnostic course," says Prazniak.

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• Payers are asking for documentation that less expensive alternatives were tried first.

Before approving a higher-priced test, such as a nuclear stress test, payers are requiring that the patient must first have a lower-priced test, such as a regular treadmill stress test. **David Hoogenboom,** CHAA, team lead/patient access liaison III in the Outpatient Access Department at Danbury (CT) Hospital, says, "This is the most common trend I am seeing."

Nurse reviewers not only want to know if other testing has been done that is more inexpensive or less complex than what is being requested, says **Aaron Robison,** CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City. They also want to know specifics as to why the provider has chosen a particular test versus less expensive alternatives.

"In some instances, it can feel like a trial of sorts, depending on the insurance carrier," says Robison. "They are trying to find 'just cause' and 'proof' that the requested procedure will result in a positive outcome that will aid the patient's care."

Capture relevant information

Patient access areas at Florida Hospital in Orlando have made these changes due to payer requests for clinical information:

• Patient access staff provide questionnaires to physician's offices.

The questionnaires ask for this information:

— previous or more conservative treatment that has been tried;

— the diagnosis or condition that is being ruled out by the requested service;

— how the outcomes of the requested service will alter future treatment plans.

• Patient access areas provide scheduling areas with a "payer matrix."

This matrix lists all contracted payers and the amount of time that each takes to make a clinical determination on authorization, from the point of receipt of clinical documentation.

EXECUTIVE SUMMARY

Patient access areas need revamped processes due to new payer requirements for detailed clinical information, to avoid a sudden increase in claims denials.

- More peer-to-peer reviews are required.
- Payers want documentation that less costly alternatives were tried.
- Providers' objectives for tests are being reviewed more closely.

"This allows them to schedule patients far enough in advance to allow the payer to review and complete the determination process," Prazniak says. This step reduces the number of rescheduled appointments due to a pending authorization status, or denials after the service is performed.

• Patient access staff perform medical necessity screening at the point of registration.

"This determines if any waiver or ABN [advanced beneficiary notice] should be obtained for potential noncovered services," says Prazniak.

• Patient access leaders participate in quarterly Joint Operating Committees with payers, medical management, patient financial services, and the managed care department.

"We discuss departmental and physician concerns, changing requirements, and clinical and financial performance from both sides," says Prazniak.

Problems with individual claims are sometimes brought up, for more timely resolution by payers.

"We have been able to solicit examples of cases where physicians state they are following clinical guidelines, and yet still receive upfront denials," says Prazniak. *(See related stories on obtaining access to clinical information, below, and educating providers on payer requirements, p. 64.)*

SOURCES

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Do you lack access to clinical information?

If so, claims denials will result

Patient access areas, especially those responsible for obtaining prior authorizations and contesting denials, must have proper access to clinical information, urges **David Hoogenboom**, CHAA, team lead/patient access liaison III in the Outpatient Access Department at Danbury (CT) Hospital.

When Hoogenboom calls to obtain retroactive authorizations for patients' tests, insurance company representatives often want to know the results of other recent tests, such as EKGs or blood work.

"It also really helps to be able to view the physician's note from the day that they saw the patient in the office and ordered the test," says Hoogenboom. "This way you can convey to the payer exactly why the physician wanted that specific test done."

It is very important that clinical staff specify why they are requesting a certain exam, so the patient access staff working on obtaining authorization have the most comprehensive information possible, adds Hoogenboom.

Before **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City, calls to obtain authorization for a service, he makes sure that he has access to the patient's full chart. "I know for certain that I will be questioned on items ranging from clinical notes to lab results, and imaging reports to pathology findings," he explains. First, Robison goes through the patient's chart to find all of the most recent and relevant clinical notes and results.

"This helps me greatly, as I can more easily answer clinical questions verbally rather than having to send in information via fax or email," says Robison.

Providing the payer with all relevant clinical data, versus just sending in the past scan or imaging results, reduces the chance that the payer's nurse reviewer or medical director will deny the request.

"Insurance companies want a full picture of the patient's care," says Robison. "Instead of waiting to receive a request for additional information, I try to send in all that I have with the initial request."

Clear communication needed

Even the way in which patient access staff word authorization requests can prevent a denial.

"At times when I thought I would get a denial for a service, it was approved — only because I was able to tie that service to another treatment that the patient had either undergone or was currently having done," says Robison.

To prove medical necessity, patient access employees must be able to communicate clearly the need for a certain procedure. "If you call for an authorization and can't explain why the service should be rendered, chances are the reviewer won't give you the chance to send in documentation before giving a denial," says Robison.

Robison says patient access employees need to access a patient's chart electronically to view all relevant clinical information.

"This makes all the difference when initiating a request for services," he says. "It's when the needed notes or findings aren't available, or haven't been done yet, that life gets difficult." ■

Lunch and learns educate providers

Patient access can clear up misconceptions

Staff members at provider offices often think, wrongly, that the hospital is responsible for obtaining or denying authorizations.

"They also believe that our department is somehow less mission-driven toward patient care," says **Michael Prazniak**, assistant director of pre-access, patient access, and patient financial services operations at Florida Hospital in Orlando.

Prazniak and other patient access leaders use "lunch and learn" meetings to educate physicians and their office staff on benefits, how a patient's out-of-pocket expenses are estimated, and the authorization process. The meetings usually begin with a discussion on the increase in peer-to-peer reviews being mandated by payers and how payers are questioning the clinical justification of physician orders.

"Office staff typically ask what clinical information needs to be provided to the payer to best support medical necessity, such as accurate CPT or procedure codes," says Prazniak.

Patient access are able to explain their role in the care of the patient. "By diligently following up on authorization to avoid denials, we free the patient to concentrate on the clinical aspects of their stay and not the financial ones," says Prazniak.

Variety of formats

The "lunch and learns" are done in a variety of ways. In some cases, a catered lunch is provided at an informal gathering. At times, patient access leaders go to an individual provider's office, but the meeting is usually held at a hospital-owned medical plaza that houses many physician offices, with various physicians and office staff members coming and going during a two-hour time frame.

Patient access leaders address questions or concerns about the benefits, authorization, and estimation process. "We meet with one group of people at a time, as determined by who is present at any given moment," says Prazniak. "Since groups come and go in the open house forum, we may answer the same questions a number of times."

Another format is a roundtable discussion, with lunch provided by patient access. "These tend to be under an hour and are more focused," says Prazniak. "At times, physicians are present; other times we host a discussion with the office staff."

Patient access recently met with a dozen office coordinators and physician assistants from a large oncology group. "There was quite a bit of lively discussion around denials, as well as sharing of information — not only between us and them, but also between each other — on how best to obtain authorizations," says Prazniak.

Teamwork is needed

In some cases, a patient's chart doesn't have enough information to prove medical necessity, warns **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City.

"Insurance companies are basically blurring the lines between patient access and clinical care," he says. "We need to work as one team to get services and tests covered for our patients."

Robison works closely with clinical coordinators and nurses, because ordering physicians are rarely available to answer questions.

"This helps immensely," he says. "They can find missing clinical items, or give me more information as to why a particular scan is being ordered instead of a different one." ■

Collections up 30% with target goals

Staff members are able to view their progress

By simply posting collection scores on a scoreboard in patient access areas, upfront collection rose significantly at Maury Regional Medical Center in Columbia, TN.

"We implemented these boards about eight months ago, and our upfront collections are up over 30% compared to the previous year," reports **Rodney Adams**, director of preservice and patient access.

Each department has its own collection goals, and so do individual registrars. Goals are based on previous collection data, with a percentage increase over the previous year — typically a 10% improvement. If the emergency department collected $25,000 in April 2013, for example, the goal would be $27,500 for April 2014. *(See related story, p. 65, on how to set collection goals.)*

"We share the daily collections numbers by department on a visual management board," says Adams. "This scoreboard contains daily metrics and goals by department, as well as whether yesterday's goal was met."

Staff members are required to look at the board daily, as are the area supervisors. Managers and directors

review the information weekly or bi-weekly, and senior leadership review progress every month. The board includes this information:

- **Historical data: in most cases, a graph of the past 13 months.**
- **A supervisor's analysis of why a particular goal was not met.**

"Problems discovered include systems issues, such as edits not working appropriately in our registration QA system, or even issues within our physician office systems causing them to send us incorrect orders," says Adams.

- **The previous day's score.**

Not meeting the collection goal results in coaching or additional training, and ultimately, it can be a cause for termination. "Exceeding the goal results in a better performance appraisal, which means a bigger raise," says Adams. "Also, it gives them bragging rights in their area."

Collections are more difficult

The biggest challenge for upfront collections has been the steady increase in patients' out-of-pocket responsibility, says **Shelita Russ**, CHAM, director of patient access services for Ochsner Medical Center — Kenner (LA) and Ochsner Baptist Medical Center in New Orleans.

"With patients now responsible for larger upfront liability amounts, the conversations at the registration desk are becoming more difficult," she says.

Russ posts collection goals to make the staff aware of how they compare to their peers. She also pairs strong collectors with struggling ones.

"It strengthens morale throughout the entire team to know that not just one person is carrying the collection load, and that all members are doing their part," says Russ.

SOURCES

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EXECUTIVE SUMMARY

Posting collection scores on a board in patient access areas increased upfront collections at Maury Regional Medical Center in Columbia, TN, by 30%.

- Staff are required to view the board daily.
- Supervisors analyze why goals weren't met.
- Some departments target the number of collections rather than dollar amounts.

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- **Shelita Russ**, CHAM, Director, Patient Access Services, Ochsner Medical Center — Kenner (LA). Phone: (504) 894-2912. Email: sruss@ochsner.org. ■

How to set collection goals

Diane Ward, assistant director of Enterprise Patient Access Services at UK Healthcare in Lexington, recently set target goals for her departments.

"Our dollar goals were set based on our total patient A/R [accounts receivable]," she reports. The department used the Healthcare Financial Management Association's (HFMA's) benchmark standard, which is that 30% of patient cash collected should be collected upfront.

"We found that taking the focus off of the dollar and putting it on the 'attempt' had better results," says Ward.

To keep the percentages at or above the target, staff would discuss options with patients that couldn't make payment in full, she explains. If a patient owed $500 and said he or she couldn't pay that amount, for example, the registrar would immediately ask if the patient could pay half. "We found it to be more effective to target the number of collections, rather than dollars," says Ward. "This leads to staff getting in the habit of asking first for the full amount." If the patient is unable to make the full payment, staff members then ask for partial payment.

"We currently target a 60% collection rate of potential for our scheduled appointments," says Ward. The potential is the amount identified prior to service as the patient's out-of-pocket responsibility.

Weekly notifications are emailed listing the top three collectors and overall collections for each of the health system's registration "teams." At Chandler Hospital, one report goes to surgery and the main registration areas for each of the hospital's two pavilions, and a separate report goes to the emergency department (ED) registration area; at Good Samaritan Hospital, a single report goes to both ED registration and the main registration area. "The transparency with staff allows them to see how they compare to their peers," she says. "It lends to some competiveness within the teams," says Ward.

Registrars are consistently meeting or exceeding the 60% rate in admitting areas. "We are collecting closer to 70% or 75%. We have discussed that it may be time to raise the bar," says Ward.

Shelita Russ, CHAM, director of patient access ser-

vices for Ochsner Medical Center — Kenner (LA) and Ochsner Baptist Medical Center in New Orleans, set 2013 collection goals by increasing the 2012 goals by 15%. Here are the results:

- In 2012, the Kenner facility collected $889,193, so the 2013 goal was adjusted to $1.02 million. The final 2013 collection amount was $1.07 million.
- In 2012, Baptist facility collected $1.4 million, so the 2013 goal was adjusted to $1.6 million. The final 2013 collection amount was $1.6 million.

"There is a friendly competition," says Russ. "For meeting goals and sustaining them for a three-month period, we give staff pizza or ice cream." ■

You should standardize your access processes

It's critical to cross-training success

After standardizing registration processes, Lexington, KY-based UK Healthcare saw a decrease in eligibility denials by 14% in every quarter in the last fiscal year.

By cross-training members of the patient access staff, the department was able to "take advantage of economies of scale," explains **Kevin McAuley**, senior manager of patient access. "We have been able to spread higher volumes of work among more individuals within our pre-registration team."

According to **David Kelly**, director of revenue cycle at Mary Rutan Hospital in Bellefontaine, OH, standardization of patient access processes is "critical to success across the revenue cycle."

"A standard process minimizes error rates, thus minimizing opportunities for claim denials," Kelly says. "It can even potentially reduce risk and disparities of care."

Lack of standardization can increase overtime costs due to an inability to "float" registrars to other areas as needed. "Standardization can also lead to vendor consolidation, which is a cost-savings opportunity," adds Kelly.

Patients more satisfied

Patients don't expect their registration experiences to differ depending on which site or service they're using, says Kelly. For example, some locations might request copays while other locations do not.

"This can be a huge point of frustration for patients," Kelly says. "We don't expect a trip to Amazon.com to vary based upon the computer we're using. We expect it to be the same, every time."

The expectation for consistency is true for registration, he says. For example, a standardized approach to financial counseling ensures that all patients in all service areas are given the opportunity to discuss their liability, payment options, and options for assistance if needed.

"Standardization in patient access drives that same 'familiarity' feeling that has driven lots of success throughout other industries," Kelly says.

Success with cross-training

Kelly says that in his opinion, "you essentially cannot effectively cross train without standardization." Although a walk-in lab registration is different from an emergency department registration or a scheduled admit, Kelly's approach is to "embrace what can be standardized, and train diligently around the rest."

Mary Rutan Hospital's patient access leaders are discussing how to best cross-train staff. While they haven't yet done an analysis, Kelly says significant cost savings are expected. "Any area doing scheduling, pre-service, or registration can be standardized and cross-trained," Kelly says. "The difficulty becomes the 'nuances' of each department and building a training program around those."

Patient access leaders at Bend, OR-based St. Charles Health System developed a standardized registration process for four hospital facilities and the pre-arrival services unit. "Our processes are standardized as much as possible," says **Bernie Andreotti**, CHAM, system manager for patient access services and pre-arrival services.

Training manuals and other registration resources are available on the hospital's shared website. "This allows us to hold everyone accountable to the same standards. It provides for consistency at all sites," says Andreotti.

Patient access employees are available to work at any of the sites, and they need to do only a site orientation when they go to a new facility.

While Andreotti has not calculated the actual cost

EXECUTIVE SUMMARY

Standardized registration processes decrease claims denials and increase success with cross-training, according to patient access leaders. Eligibility denials decreased by 14% each quarter in the last fiscal year at UK Healthcare.

- Costs are saved due to less overtime pay and fewer errors.
- Short-staffed areas can pull registrars from other areas.
- Patients expect consistent registration processes.

savings of standardized processes, she says there are decreased overtime costs. "But at times for us, it is not overtime. It is being able to keep a service open and not back patients out the door with the wait times," she says. "The amount of times that we have been able to share staff has been invaluable." *(See related story, below, on benefits of standardizing patient access processes.)*

SOURCES

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Access area benefits from standardization

Staffing is more accurate

At Louisville, KY-based Baptist Health's seven hospitals, the focus on standardizing patient access and scheduling functions started two years ago, at the same time a new registration system was being implemented.

"Used properly, standardization has potential to be the most powerful tool within a healthcare system, but is often the least-used tool," says **Myndall V. Coffman,** MBA, system director of patient access and scheduling for Baptist Health.

After processes were standardized, says Coffman, "as expected, increased productivity, improved quality, and cost reduction has occurred." Here are some benefits the department is seeing:

• Patient access staff from other facilities are able to help with special projects or support short-staffed areas.

"When it was time to go live, one facility had some unexpected turnover," says Coffman. "A couple of staff members from another hospital were able to step in and help."

• Patient access areas no longer need to develop their own processes, policies, and procedures.

"This contributes to significant savings," says Coffman. "Managers are able to spend their time on perfecting those processes instead of developing them."

• Ensuring operations are consistent has improved the "clean claim" rate, and reduced denials.

"Selecting the proper insurance had become a frustration for staff members simply because the way the master was built appeared to be different," Coffman explains.

More accurate staffing

Standardized registration processes allows **Kevin McAuley,** senior manager of patient access at UK HealthCare in Lexington, to staff more accurately based on patient volume.

"When registration processes are not standardized, patient interaction and/or task times can vary greatly between team members," says McAuley. "This will prevent you from having a clear picture as to what your true staffing needs are."

When established properly, standardization provides the framework for what is to be achieved in each patient interaction, says McAuley. "This leads to better customer service, patient confidence, and more efficient clinic flow or throughput," he says. ■

How likely is patient to pay?

Offer patients help upfront

Few registration areas use propensity to pay software to determine a patient's ability to pay, says **Brendan Fitzgerald,** research director of HIMSS Analytics, a Chicago-based organization focused on improving health through information technology.

Currently, says Fitzgerald, "it's usually done on the back end, not so much on the patient access side," he says. If hospitals get this information at the point of registration, however, patient access staff have an opportunity to offer patients some assistance.

"Having that information upfront can certainly offer hospitals a way to help patients if they are at risk in terms of payment, versus hoping to collect money on the back end," he says.

While most patient access areas have automated insurance verification, eligibility, and scheduling processes, propensity to pay and charity screening "haven't really come into the fold yet," says Fitzgerald.

One reason might be that hospitals are directing significant resources to prepare for the switch to ICD-10, which has put other changes on hold. "Despite the recent pushback of the ICD-10 deadline to 2015, orga-

EXECUTIVE SUMMARY

Propensity to pay software can help determine a patient's ability to pay, but few patient access areas use this technology.
- Staff can offer patients assistance at the time of registration.
- The tool often determines that patients are likely to be eligible for Medicaid,
- If patients don't qualify for Medicaid, an effort is made to quality them for charity.

nizations will keep their focus on the coding transition," says Fitzgerald. "Once that transition has happened, we could see hospitals implement some of these lagging solutions."

"Brief snapshot" at registration

Patient access staff at St. Anthony's Medical Center in St. Louis, MO, ask patients about family size and income, so they can determine whether the patient is likely to be eligible for Medicaid or another type of assistance.

"It is a brief snapshot," says **Kim Setlich**, patient accounts manager. "This information gives us a quick view earlier in the process. We use it as a tool to capture as much upfront need as possible."

Patient access employees often discover that patients are likely to be eligible for Medicaid. "It allows us to find what assistance the patient needs, so the patient will not decide against treatment based on cost," says Setlich.

The hospital's Medicaid eligibility department then helps patients with the application process. "We look at all scenarios," says Setlich. "We want to make sure the patient has resources available to pay their bill."

If patients don't qualify for Medicaid, an effort is made to quality them for charity. "We try to work with them best as we can, to make sure they get the care that they need," Setlich says. ■

Spend an hour in registration areas

Managers report improved morale

Administrative rounding in patient access areas "has proven hugely successful with our staff," reports **Keith Weatherman**, CAM, MHA, associate director of service excellence for corporate revenue cycle for Wake Forest Baptist Health in Winston-Salem, NC.

"When visited one on one, staff feel free to offer great suggestions," Weatherman says. "They feel good that the 'higher up' folks care."

Weatherman has heard dozens of different concerns while rounding. He has been able to resolve nearly 100% of the issues raised, which have ranged from tools that are needed, issues with management, training needs, and process improvement.

Each morning, **Gloria Vargas-Gonzalez**, registration supervisor at Elmhurst (IL) Memorial Healthcare, rounds with her staff in the emergency department (ED), outpatient, surgery, endoscopy, and admitting areas. She spends from 40 to 60 minutes rounding every day.

"I start with some simple conversation to meet and greet the staff each day," says Vargas-Gonzalez. "I think it makes them feel important and that they work in a caring environment."

Vargas-Gonzalez first asks how the employee's day is going, and if he or she needs any kind of help. "I also assess the volume and staffing, to make sure we are providing excellent customer service," she says. *(See related story, p. 69, on how staffing concerns can be resolved with rounding.)*

If Vargas-Gonzalez doesn't round in a certain area on a particular day, the employees let her know she was missed. "We get to say hello and have a simple conversation. It's one of the things that the employees look forward to," she says. Here are some concerns Vargas-Gonzalez has resolved during rounding:

• Outpatient registration staff reported delays in appointment scheduling due to misdirected patients, and patients presenting without a written order.

"The amount of time spent resolving these issues varies and can be time-consuming, causing a delayed reaction for other appointments," says Vargas-Gonzalez. "If needed, I will help register patients that may be waiting."

At times, technicians are unable to perform a test because there is no physician order. In these cases,

EXECUTIVE SUMMARY

By spending about an hour rounding in registration areas, patient access leaders can resolve many staff concerns and boost morale. By rounding, managers can do the following:
- Step in to register patients themselves.
- Adjust staffing based on volume surges.
- Intervene if payer systems are down.

Vargas-Gonzalez apologizes to the patient and gives assurance that staff are working to correct the problem. Next, she calls the provider's office to let them know the patient's test will need to be rescheduled if the order isn't obtained.

"People have choices, and if we are a repeat offender they will look elsewhere. We don't want that," she says.

• In the ED registration areas, Vargas-Gonzalez continually looks at the tracking board to assess volume.

She assists with registrations if needed, or adjusts staffing to meet the department needs.

• Vargas-Gonzalez answers any questions registrars have about insurance.

"If they code something incorrectly, they are able to quickly change it on the spot after talking to me, rather than the claim going through billing and getting rejected," she says.

• Vargas-Gonzalez recently helped staff when a payer's system was down, which made online verification of benefits impossible.

"If it doesn't come back quickly that the patient has eligibility, then I just ask them to document the account," she says. Then when the system goes back up, we are able to capture the eligibility afterward."

Vargas-Gonzalez called the payer right away to report the problem. "They were then able to alert us when the system is recovered, so we knew we are able to view the eligibility again," she says. "That has a big impact on our financials."

• Vargas-Gonzalez got approval for desktop scanners that were repeatedly requested by staff.

"Right now, we are doing everything on paper, and at times, it doesn't come out correctly," she says. With the new scanners, the order and insurance card are scanned into the system.

• At times, staff members ask Vargas-Gonzalez if they can meet with her privately. These discussions often involve issues with coworkers, such as tardiness, but she is often able to head off problems by informing colleagues in advance if one of their colleagues is running late.

"I let them know something is going on. Someone may have a doctor's appointment and isn't going to be back in time," she says. "It's important to keep everyone informed."

SOURCES

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Managers must act on sudden surges in volume

Extra person 'makes a big difference'

While rounding in an outpatient registration area at Elmhurst (IL) Memorial Healthcare, registration supervisor **Gloria Vargas-Gonzalez** saw that only one registrar was working, despite many patients waiting to be registered.

The problem was that patients from an off-site location were being redirected to the hospital for diagnostic testing because of equipment problems. Vargas-Gonzalez quickly pulled a registrar from another area to help, which prevented dissatisfied patients and overworked employees.

"That one extra person makes a big difference," she says. "It makes staff feel important. We've done something about it, rather than have them struggle."

No problems with lunch breaks

When radiology staff reported increased patient volume, Vargas-Gonzalez came up with a solution by giving a part-time employee extra hours.

If an area is short-staffed, an extra person means that everyone can still take their scheduled lunch break. "I'm a big believer in cross-training, so we move people around constantly," says Vargas-Gonzalez. "It's a huge disatisfier if someone can't take lunch at their scheduled time."

Vargas-Gonzalez first started cross-training her staff when she took a close look at the census in the emergency department (ED). "We had three people starting at 6 a.m. in the ED, and it doesn't warrant that," she says. Some ED registrars now work in outpatient registration areas until 9 a.m. "That way, staff can increase their knowledge, and we can use them in case someone calls out in another department," Vargas-Gonzalez says.

Staff members appreciate being able to work in other areas instead of having their hours cut.

"I can pull someone from the ER and say, 'We had a call off for 6:30 in outpatient. I need you to work there until we can find coverage,'" she says. "That way, it doesn't create overtime." ■

Justify need for additional FTEs

Patient access areas can quickly become short-staffed if leaders don't pay attention to changing patterns of patient flow, warns **Mitch Mitchell**, president of T.T.

Mitchell Consulting, a Liverpool, NY-based consulting firm specializing in revenue cycle and technology.

Another common problem is that patient access fails to work with ancillary departments that provide outpatient services, he says. For example, many hospitals have a high influx of patients coming in the early morning to have lab work done before heading to work.

"The same thing can happen the first hour after 3 or 4 p.m., when people like to stop in before heading home," says Mitchell. Similarly, some urban hospitals typically have a high rate of patients coming into the emergency departments (EDs) on Friday and Saturday nights. "But they rarely staff them well enough," says Mitchell.

This situation sometimes occurs because patient access leaders don't take the time to observe registration areas during all shifts. "So they create schedules based on what they think is happening and not what is actually happening," says Mitchell.

Because every hospital tracks admissions and admission times, Mitchell says patient access leaders can put those numbers to use. "Figure out when admissions are higher on a regular basis," he advises.

Working for other departments

Some departments habitually use patient access staff to do work, and management is unaware that they're doing this work. This situation results in longer wait times in registration areas.

"I remember making spot checks here and there, and not seeing registration personnel anywhere, because of an errand some doctor or nurse sent them on," says Mitchell.

At large hospitals, registrars are sometimes asked to handle some of a department's administrative work, particularly if a position was eliminated in that department. "It's possible that they might also be asked to run errands for medical records or even take lab work to the lab. I've seen it happen," says Mitchell.

In one case, Mitchell had to put a stop to registration staff being asked to do work for the ED. "They were putting down linens and sometimes running to the cafeteria to get meals for extended stays in the ED," he says.

By putting a stop to these practices, patient access leaders can reduce registration wait times.

"There's always plenty of work within the department for them to do when things slow down; at least I've always found that to be true," says Mitchell.

Quantify FTEs needed

The National Association of Healthcare Access Management (NAHAM) is working on quantifying the value of patient access professionals at their respective facilities, reports **Mike Copps**, executive director of NAHAM. "Our recently released Registration/FTE Calculator is a step in this direction," he says.

The Registration/FTE Calculator is an online tool to help patient access managers to prepare budgets, determine appropriate staffing, respond to workforce cutback recommendations, and advise senior management on future staffing needs. *(For more information on NAHAM's Registration/FTE Calculator, which is available only to NAHAM members, go to http://www.naham.org/?FTE_Calc.)*

The tool helps determine and document staffing requirements for both pre-registration and registration areas. "It groups numerous patient access tasks and processes into 20 distinct components and helps determine the time required to perform each component," says Copps.

Based on the data that is input, the tool calculates the total time expected to complete a registration, as well as the FTEs and cost required to perform them. "Staff are also able to compare registration times and FTE requirements to peers," adds Copps.

SOURCES

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EXECUTIVE SUMMARY

Patient access areas risk being short-staffed if leaders don't monitor patient volumes closely. Patient access managers can do the following:

- Take the time to assess registration areas during all shifts.
- Determine when volume of admissions is consistently higher.
- Learn if staff members are performing tasks for other departments.

Principles help consumers obtain healthcare price info

A task force made up of healthcare leaders and consumer representatives has reached consensus on how consumers can obtain clear and easy-to-understand information about their financial obligation for healthcare services, before any tests or procedures are performed.

Led by the Healthcare Financial Management Association (HFMA), the task force developed guiding principles and recommendations for price transparency that highlight how hospitals, physicians, and health plans would share reliable information on healthcare prices with consumers. Combined with other relevant information, such as quality and safety, price information will help consumers make more informed healthcare decisions.

"People everywhere want to be smart healthcare consumers, but information about healthcare prices is not easily accessible," said **Joseph J. Fifer**, FHFMA, CPA, president and CEO of HFMA. "For too long it has been unclear how consumers should go about getting price information — who to ask, what to ask for, or what the information even means when they do receive it. This approach is a game changer."

The task force included representatives from America's Health Insurance Plans, the American Hospital Association, Catalyst for Payment Reform, Community Health Advisors, and others, including a patient. Working together, stakeholders identified how anyone can receive reliable price information, tailored to insurance status. Participants agreed that patients who are insured should rely on their health plans to provide price information. The task force also agreed that hospitals should serve as the primary price information resource for uninsured patients and those seeking care outside of their insurance network.

Stakeholders agreed that consumers should be able to make meaningful comparisons before common elective services with usable price estimates and quality information, enabling consumers to understand the value of the care they will receive. The task force also called on health plans and providers to make price information available in easy-to-understand formats so that consumers can make the most of the information at their disposal.

Task force participants called the release of the guiding principles and recommendations a critical step toward greater transparency of price information.

"It's entirely reasonable for consumers to expect better access to price information," said Fifer. "We are calling on all healthcare stakeholders to acknowledge that and to deliver the clear, reliable price information consumers are looking for. By achieving consensus about the roles all stakeholders should play, we have taken a giant step in the right direction."

To see highlights of the guidelines, go to http://bit.ly/1rq5ErV. ■

CMS made $7.5 million in incorrect hospital payments

Clinic visit payments not always correct

The Centers for Medicare & Medicaid Services (CMS) found in its improper payment reviews for 2008 through 2011 that evaluation and management (E/M) services were frequently miscoded. On the basis of sample results, the Office of Inspector General (OIG) of the Department of Health and Human Services estimated that CMS made incorrect payments to hospitals totaling $7.5 million during calendar years (CYs) 2010 and 2011.

Medicare payments to hospitals for E/M outpatient clinic visits vary on the basis of whether patients are new or established. An established patient has been treated more than once at the same hospital during a three-year period. In 2009, two healthcare entities paid more than $10 million to settle allegations that they fraudulently billed Medicare for E/M services (OEI 04-10-00180).

This is the first audit that OIG has conducted relating to E/M outpatient clinic visits (clinic visits). The objective of the audit was to determine whether CMS correctly made selected outpatient payments to hospitals for established patients' clinic visits for CYs 2010 and 2011.

CMS made incorrect outpatient payments to hospitals for established patients' clinic visits. Of the 110 randomly sampled line items for which CMS made Medicare payments to hospitals for clinic visits (HCPCS 99203 to 99205) during the audit period, two were correct. In addition, OIG treated six line items as non-errors (correct) because, for three line items, hospitals refunded incorrect payments totaling $54 prior to OIG's fieldwork and, for three line items, hospitals were under investigation. CMS overpaid the remaining 102 line items by a total of $2,190.

The hospitals had not refunded these overpayments by the beginning of the audit:

• For 80 line items, hospitals incorrectly used new patient HCPCS codes to identify clinic visits for estab-

COMING IN FUTURE MONTHS

- Stop patient complaints due to long wait times
- Assess staff competency with mystery shoppers
- Use patient portals to dramatically boost collections
- Satisfy patients with self-registration options

lished patients, which resulted in incorrect payments totaling $1,653.

• For 19 line items, in addition to incorrectly using new patient HCPCS codes for established patients, hospitals did not use correct HCPCS codes to describe the levels of services furnished, which resulted in incorrect payments totaling $307.

• For three line items, hospital officials informed us that they billed for clinic visits without supporting documentation, which resulted in incorrect payments totaling $230.

The hospitals attributed the incorrect payments to clerical errors, staff not fully understanding Medicare billing requirements for clinic visits, reliance on the code that the physician selected for the visit, or billing systems that could not identify established patients.

Also, CMS does not have edits in place to identify Medicare payments for patients who were already registered at a facility.

OIG recommends that CMS work with its Medicare administrative contractors (MACs) to:

• recover the $2,190 in incorrect payments identified in the sample;

• provide additional guidance to hospitals on billing clinic visits for new or established patients, which could result in savings totaling $7.5 million over a two-year period;

• resolve the remaining 378,376 line items and recover the overpayments to the extent feasible and allowed under the law; and

• direct MACs to instruct hospitals on the need for stronger compliance.

This report is available to the public at http://1.usa.gov/1jHP00U. ■

Congress delays Medicare pay cuts

President Obama has signed the Protecting Access to Medicare Act of 2014 (H.R. 4302) into law. This law marks the 17th time Congress delayed the cuts to physician reimbursements established with the Sustainable Growth Rate (SGR) under Medicare. The bill delays a 24% cut to the payments.

Both chambers of Congress moved quickly to pass this bill after it became obvious no agreement would be reached on how to pay for the permanent "doc fix" bills.

The SGR was created in 1997 by Congress as a mechanism for tracking the payments with economic growth. The SGR became a problem within a few years as increases in healthcare costs substantially outpaced economic growth. This development resulted in the creation of a multi-billion dollar shortfall for the funding of Medicare payments to physicians.

Members on both sides of the aisle and in both chambers spoke about the need to permanently fix the SGR. However, they recognized the immediate need to prevent the delay's expiration and prioritized this temporary patch over a lengthy negotiation process to pass a permanent fix that would result in the expiration of the SGR delay. ■