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INSIDE

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`Skinny' network plans growing — Patients blindsided by changes

Patient access faces lost revenue and unhappy patients

In 2013, many patient families in the Seattle area purchased an insurance plan from a large payer that included Seattle Children's Hospital. A few months later, the payer transitioned the families to a "narrow" network that no longer included the hospital.

"The payer did this without changing the name of the plans, and, according to our families, without enough communication to explain the change," says **Suzanne Vanderwerff**, senior director of revenue cycle value stream at Seattle Children's.

As a result, patient access staff are seeing many patient families trying to schedule appointments with doctors that their children have seen many times before — often, since birth — but their doctors are no longer in network. "We have to explain to the families that they will now have to pay out-of-network rates to be seen at our hospital," says Vanderwerff.

More health plans are looking to "skinny down" their networks, reports **Michael Lawton**, vice president of managed care and network development at UF Health Shands Hospital in Gainesville. "As an academic health system, we have a unique cost structure that does not allow us to compete in

EXECUTIVE SUMMARY

Patients are increasingly presenting with out-of-network coverage, due to more "narrow" networks in health plans. Patient access needs revamped processes to confirm eligibility, inform patients, and apply for patient-specific agreements.

- Internal and payer-specific tools can determine if patients are in network.
- Some departments have added staff to educate patients on the need to apply for exception requests.
- Patients are typically unaware of their out-of-network status due to similar-sounding names of health plans.

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the same way a community hospital does," he says. "So we are often left out of these 'skinny' networks."

At Emory University Hospital in Atlanta, patient access employees have had problems with several locally available plans purchased on the Health Insurance Marketplace, which are out-of-network for Emory hospitals. "Patients get really upset to discover their plan excludes us," says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle management. "We've collaborated with our insurance verification vendor to catch these during pre-admit."

Emory's patient access leaders also have asked carriers to provide better education to their plan holders. "The situation is complicated by the fact that the plans will pay for emergency or transplant-related services," says Kraus. "These are difficult to catch upfront in our largely automated system."

Eligibility software used by patient access employees at Cottage Hospital in Woodsville, NH, gives immediate information on the patient's benefits, but doesn't indicate whether the hospital is in-network.

For outpatient clinics and therapy services, patient access employees call the patient's insurance carrier prior to the initial visit and verify in-network status. "This way, we can inform the patient upfront of where their services stand," says **Jennifer White**, director of patient access.

The state's exchange plan selected a very limited number of facilities and providers as in-network. "Everyone else is out-of-network," says White. "This has been a challenge. Patients do not understand their plans, and facilities and providers have limited understanding."

Staff have to tell patients that the hospital is not in-network with their plan and that services will be out-of-pocket. "Patients are not happy. They feel it is our fault, but we were not given an option," says White. "It is a challenging conversation to have."

Better verification processes

Before 2014, there was no need for patient access leaders to put significant emphasis on determining whether patients are enrolled in "narrow" network plans. "But that has changed," says Vanderwerff.

Patient access employees at UF Health Shands use various systems to determine and confirm patients' network eligibility. "Through our admission process, whether through our physicians' access area or the hospital admitting area, we have UF Health System tools and payer-specific tools that we use," says Lawton.

Many insurance products have similar names, patient familiarity with their insurance is low, and insurance cards don't always reflect the most updated information. "There is neither an easy nor an efficient process to identify if a patient is out-of-network," says Vanderwerff.

At Seattle Children's, patient access staff members search payer website portals to confirm what insurance product the patient has, or they call the health plan if the portal doesn't provide this information. "Many of the products sold by the insurance plans have very similar names," adds Vanderwerff. For this reason, patients usually are unaware of their out-of-network status.

"A patient may think he or she is purchasing a product that includes the same physicians and facilities as the previous plan," says Lawton. "Later, they find out that this is not

the case."

Patients sometimes find that the services they need are not available in the network or are only available by traveling significant distances. In these cases, out-of-network hospitals can sometimes work with the plans to secure patient-specific agreements. "These agreements, while occasionally successful, often lead to delays in care, frustration for the patients and family, frustration for the physicians, and potential harm to the patient," says Lawton.

Seattle Children's Hospital offers many pediatric specialty services that patients can't get anywhere else in the region.

"We spend a great deal of time filing exception requests on behalf of patients, so that families can pay the in-network rates," says Vanderwerff.

Scheduling for patients with "narrow" network coverage that doesn't include Seattle Children's takes significantly longer than usual. "This is because the patient families need us to explain the extra steps that they, and we, must take before we are able to schedule an appointment," says Vanderwerff.

In some cases, staff members file "exception requests" with the payer so the patient can continue to be seen at the hospital. However, this filing is possible only if there is no in-network provider in the area who can provide the pediatric specialty services the patient is seeking.

At Seattle Children's, dedicated, knowledgeable staff were added to handle a large number of exception requests to narrow network payers on behalf of out-of-network patients. "They spend much of their time educating patients on the need to file an exception request," says Vanderwerff. "Most people outside of the healthcare industry do not understand the plans or the coverage."

SOURCES

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Stop `no auth' denials with new processes -- Access is struggling with new payer requirements

Many payers are requiring authorizations for services that have not needed it in the past, reports **Aaron Robison**, CHAA, a patient coordinator and former financial advocate at University of Utah Health Care in Salt Lake City.

"Our department has been working tirelessly on our prior authorizations, to combat the rise in needed approvals," he says.

Insurance companies are updating their medical policies to combat waste or unnecessary treatments, notes Robison. "Though this is a good idea, it can place great stress on our team," he says. "We need to make sure that everything that is done for our patients has an authorization in place if needed."

This situation means continually calling insurance companies or researching the payer's medical policies online. Both of these tasks are time-consuming, says Robison, but "we cannot afford to miss obtaining the approval. We cannot bill the patient for procedures that we failed to get authorized."

Patient access leaders at Ann & Robert H. Lurie Children's Hospital of Chicago are seeing more payers requiring pre-certification for tests such as echocardiograms, which traditionally have not required pre-certification, reports **Lisa Lenz**, CPC, CMPE, administrator of the physician revenue cycle.

"Payers are constantly adding to the types of procedures that need pre-certification," she says. Patient access staff subscribe to a service that monitors payer websites daily to keep up on the changing authorization requirements (Payer Alerts service, Experian Healthcare, Maple Grove,

EXECUTIVE SUMMARY

Payers are requiring authorizations for many additional procedures, which results in increased claims denials and dissatisfied patients. Patient access departments are making these changes:

- sending correct information to payers to show the medical need;
- asking payers for the best way to submit authorization requests;
- contacting ordering physicians to learn the reason for tests.

MN).

Due to increased authorization requirements, health benefit associates at Castle Rock (CO) Adventist Hospital check online or call payers for all high-tech radiology procedures, says **Jeryl Wikoff**, patient access manager. Here are other changes that the department made:

- Staff members sign up for emails from payer websites, so they are notified when updates are made.
- Staff members work closely with practice managers so they know that a referral is required.
- Staff members are kept informed of payer changes by the business office.

To keep up with new authorization requirements, University of Utah's patient access leaders created additional work queues in the hospital's Epic system so accounts can be tracked and monitored while they are waiting for authorizations. "If an account hits a pre-auth work queue, then we know to start the authorization process for the ordered service or procedure," says Robison. The work queues give staff the ability to run reports to see how many accounts were not authorized or were missed for some reason.

"The trick is to stay ahead of the curve as best as possible," says Robison. "Without knowing when an insurance company will update their policies, however, it is difficult to do so."

Charges written off

Depending on which tests or services are denied due to no authorization, hundreds to thousands of reimbursement dollars can be lost, Robison emphasizes.

"If it was cancer-related and a high-dollar procedure, the loss could easily be close to $100,000 or higher," he adds. For example, if a chemotherapy regimen is given without prior authorization, and the insurance company does not allow for retro-authorizations, a sizable amount of money would have to be written off.

In some cases, charges are written off that would otherwise have been covered.

"Most insurance contracts do not allow patients to be billed for non-authorized services," explains Robison. "This means that we have no choice but to take the hit to our revenue."

Denials are appealed

About 90% of "no-auth" denials are successfully appealed at University of Utah. "We submit retro-auths and appeal denials vigilantly," says Robison.

Generally, most major insurance companies accept appeals of denials due to no prior authorization on file, he notes, but that acceptance doesn't mean the denial will be overturned. With this position in mind, every denial due to lack of a pre-authorization is taken seriously.

"If the clinical team performs services without notifying us first, we then communicate to them the need to always go through patient access first, unless the services are needed for emergent reasons," says Robison. (*See related stories on communication with clinical areas, below, and additional information required by payers, p. 113.)*

SOURCES

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- Jeryl Wikoff, Patient Access Manager, Castle Rock (CO) Adventist Hospital. Email: JerylWikoff@Centura.org. ■

Work with clinical areas to obtain authorizations — Ask them to involve access from the beginning

"Clear and open" lines of communication between the clinical team and patient access is the single best way to prevent claims denials due to no authorization, according to **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City. However, this step remains a significant challenge for the department.

"When an account appears on our work queue for authorization, we need to be able to go to that ordering doctor and his team to find out everything we can regarding why the test was ordered," he explains. Patient access staff members ask for any evidence to show that the test is medically needed.

This step is more difficult when external providers request to have procedures for their patients at the facility.

"It can be quite a challenge to get medical records from their office to submit to the insurance companies," says Robison.

Get "on same page"

With recent changes in healthcare and a strong focus on reducing medical waste, providers are becoming better communicators as to why they wish to have their patients undergo a certain test or procedure, says Robison.

"When everyone is on the same page, getting an authorization isn't that difficult," says Robison.

He adds that a clear precedent has to be set to encourage good communication between clinical and financial teams.

"It is only through good communication that the organization can avoid nasty appeal processes, as well as having to write off testing that would have otherwise been covered," he says.

A win-win situation

Providers and patients benefit from a better understanding of the role of patient access, Robison emphasizes.

"Instead turning to the department only after a denial has occurred, it is better to have them involved from the beginning with a patient's plan of care," he says.

This involvement allows the patient access team to communicate with patients about their expected costs, as well as keep an eye on any treatments that might require an approval. For example, if a patient might require a second infusion of donor cells after undergoing a stem cell transplant, providers in the bone marrow transplant department inform patient access of this requirement. "It is in their best interest to give us a heads-up on a possible second stem cell infusion," says Robison. "That way we don't find out at the last minute."

Patient access is then able to obtain an authorization if one is needed. "I have found that providers respond to the hard truth of potential monetary losses when poor communication is prevalent throughout a department," says Robison.

"Everyone wins" if patient access and the clinical care team work together during a patient's treatment, he emphasizes.

"In this light, you are creating a continuum of care for the patient. The care team is not just for clinicians," says Robison. ■

Send all the information you can to payers -- `Littlest thing' can avoid denied claim

Sending the correct information to the insurance companies to show the medical need for services has become "quite a task" for patient access, says **Aaron Robison**, CHAA, a patient financial advocate at University of Utah Health Care in Salt Lake City.

Insurance companies routinely require information to be sent with authorization requests to ensure that the service is truly necessary and not just a preference of the ordering physician, Robinson explains.

Lisa Lenz, CPC, CMPE, administrator of the physician revenue cycle at Ann & Robert H Lurie Children's Hospital of Chicago, says, "We have seen an increase in the amount of clinical information that needs to be sent in order to have a high-ticket medical imaging procedure authorized. Verifying that *all* of the pertinent information is sent with the authorization request is paramount to avoid any appeals process which could delay care."

Review process is hurdle

The time it takes for payers to authorize a procedure is a continual problem for patient access staff, says Robison. "Some insurance companies can take up to 15 business days to go over the request," he reports. "This can be quite frustrating."

Payers have clear indications on what they consider to be an urgent request, he adds. When providers say a service is urgent, the payer often disagrees because the patient's condition is not life-threatening. "The best way to circumvent the long waiting times, I have found, is to know the best way to submit the authorization request, whether it be online, fax, or phone," says Robison.

When staff members submit a request with a clear timeframe listed for the procedure, Robison says insurance reviewers typically do their best to honor that tentative schedule. To speed the process, access send in all the information they possibly can for every authorization request.

"At this point in the healthcare industry, insurance companies are not leaving any stone unturned," Robison warns. "Sometimes the littlest thing can avoid a denial — anything from a lab result to a specific type of imaging. ■

Flex access staffing based on volume — Fixed model approach is no longer effective

One of the biggest challenges in staffing patient access areas is incorporating volume flexing into the staffing model, says J**en Nichols**, senior director of revenue cycle operations at Kaleida Health in Buffalo, NY. "At many organizations historically, patient access was staffed in a fixed model," she explains.

Previously, a department might have scheduled three registrars on the first shift, Monday to Friday, for a particular area. "Staffing to a fixed schedule prevents us from responding – flexing down or up – to changing business priorities and volumes," says **Diane Pazderski**, RN, Kaleida Health's director of patient access services.

For example, ED volumes dictate a staffing model in which there are fewer staff members early in the day and additional registrars on the evening shift, while ambulatory surgery departments need earlier staff assignments. "With the dynamic financial environment in healthcare, the challenge is to now look to reflect volume in our staffing structures," says Nichols. "We flex to volume both in budget planning as well in daily operations." Here are some approaches to do this flexing successfully:

• Assess volume patterns.

"Different departments experience different patient flow patterns and arrival times," says Pazderski. "Registration services need to be fluid and reflect the individual needs of those departments."

There are some areas of patient access, such as the emergency department, that have unique challenges in staffing to volume. "But done carefully, volume can be a key staffing indicator in those areas as well," says Nichols.

• Design staffing to support "staggering" start and end times to reflect business needs, and vary shift length to ensure optimal coverage.

A registration area might need four separate starts of 5:30 a.m., 7 a.m., 8 a.m. and 9 a.m., for example. "All cover the first shift, but at staggered intervals, to provide peak coverage aligning with peak volume," says Pazderski.

• Evaluating replacement of FTEs against volume trends.

"FTEs may be shifted to other areas," says Nichols. "In some cases, volume changes may warrant reduction or addition of FTEs."

• Site managers and supervisors may adjust staffing throughout the day if needed.

"Routine staffing adjustments must be incorporated in daily, and even hourly, operations assessment," says Pazderski.

Workload boosted 30%

To ensure patients are registered timely and accurately, patient access managers have to staff according to anticipated volume, warns **Mark Sammartano**, interim director of revenue cycle and managed care at Waterbury (CT) Hospital.

"In order to establish these schedules, patient access managers have to work from a baseline, using productivity to determine capacity," says Sammartano. "This facilitates a quantitative approach to allocating FTEs."

Stacy Calvaruso, CHAM, assistant vice president of patient access services at Ochsner Health System in New Orleans, says her biggest staffing challenge is that as the medical industry continues to change, the scope of responsibility for patient access areas continue to expand. "In most hospital registration areas, there are over 140 decision points in any given patient registration," says Calvaruso. The push to capture more information real-time from the patient has increased the workload for front-end staff members an average of 30% over the last five years, she reports.

"Meaningful use, HITECH [Health Information Technology for Economic and Clinical Health Act], balanced billing notifications, accountable care organizations, and increased financial counseling responsibilities related to the exchange plans and high-deductible plans are all common responsibilities for patient access representatives," says Calvaruso. Here are approaches used

EXECUTIVE SUMMARY

Patient access managers need productivity data to staff registration areas appropriately based on volume, particularly for areas such as the emergency department.

- Quality and quantity measures are needed.
- Manual sampling methods often are outdated or inaccurate.
- Systems can integrate several key tasks performed by registrars.

by Ochsner's patient access leaders:

• They are proactive in evaluating staffing models.

"As we do with our productivity metrics, we look at our history information as well as our future visit information," says Calvaruso.

• They look at schedules by location, provider, day, hour, week, and months.

"We use this to determine if we can or should flex our staff members," says Calvaruso.

• Supplemental staff personnel are used to help offset overtime, call-ins, Family and Medical Leave Act (FMLA), vacations, and holidays.

"This enables us to control expenses as well as allow staff members to take the time off that they work hard for whenever possible," says Calvaruso.

• The department cross-trains in many areas, including hospital admitting to ED admitting, clinic to hospital registration, and facility to facility.

"Having consistency in one master training program and one operational philosophy, we are able to utilize our team members in other locations to help with staff shortages, go-live events, and weather events," says Calvaruso. *(See related stories on additional work done by patient access, below, and tools to staff appropriately, p. 116.)*

SOURCES

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When staffing, don't forget `other' work

Staffing models don't always factor in additional tasks performed by patient access, warns **Stacy Calvaruso**, CHAM, assistant vice president of patient access services at Ochsner Health System in New Orleans.

"Often we are the first call that is made when help is needed," she says. Patient access often are called upon for special projects such as outbound calls for special programs such as insurance company well visit scheduling plans, denial "clean-up" projects, or returned mail projects.

"We often call ourselves the IS, dietary, transport, maintenance, telephone and TV support desk, since we generally are the first folks that are called when someone has a problem," says Calvaruso. It is difficult to factor in these extra tasks when creating staffing models, she adds.

"A lot of it is done on a case-by-case basis," says Calvaruso. "Based on an educated guess, we determine staffing need. There is no magic formula."

Inventory extra tasks

At Kaleida Health in Buffalo, NY, several types of data are used to create staffing models: historical, projected, and trending volume; productivity; benchmarks; patient satisfaction; and provider satisfaction.

"A challenge in using productivity alone is to ensure that you have carefully considered and accounted for all of the 'other' tasks that sometimes find their way to the registration desk," says **Jen Nichols**, senior director of revenue cycle operations. For example, registrars might enroll patients in patient portals or perform data collection.

Increasingly, registration completes additional work for the organization, says **Diane Pazderski**, RN, director of patient access services. Registrars field patient and provider calls, contact insurance companies, obtain authorizations and verifications, help with patient surveys, and more. "These are important elements of patient access, but they take time and resources," she notes.

'Diligently inventory'

Patient access leaders must "diligently inventory" these tasks and carefully evaluate the most appropriate method and location to complete these, says Nichols. For example, in pre-registration, managers review historical call volumes and compare them to "scheduled" volumes. "We can identify the percentage of return calls and factor that volume into our staffing and benchmarks," says Pazderski.

Failing to include extra work can result in inadequate staffing and inaccurate data.

"There will be decline in staff morale when they are consistently unable to achieve the productivity target," Pazderski says. ■

New tools needed to staff access — Flex according to volume at any given hour

In the past, the only way for patient access managers to develop productivity standards was through time studies, says **Mark Sammartano**, interim director of revenue cycle and managed care at Waterbury (CT) Hospital.

"More often than not, staffing was based on a hit-or-mix approach. This is no longer the case," Sammartano says. "Multiple tools exist today that provide management with both quality and quantity measures."

These systems integrate several key tasks: insurance verification, medical necessity screening, address validation, and point-of-service estimates. "At Waterbury Hospital, we are in the process of deploying such a system," says Sammartano. "These tools not only assist with these tasks, but also provide the information interactively."

Reduce delays, denials

Patient access departments at Waterbury Hospital are implementing tools from Plano, TX-based DCS Global.

"We are two weeks into implementation. It will take a month or two to accumulate enough data for analysis," says Sammartano. "However, we can identify performance variations between individuals now."

The goal is to reduce avoidable insurance payment delays and denials, says Sammartano. Staff members achieve this goal by getting accurate and complete information before the patient leaves the registration area and by providing an accurate estimate of the patient's balance at time of service.

Without this information, he says, patient access leaders must resort to using manual sampling methods that are sometimes outdated or inaccurate. "Errors can be missed, and feedback to staff is haphazard," says Sammartano. New systems provide immediate feedback so corrective action can be taken before an error affects the account.

"Analytics gives management a true picture of capacity, based on objective data that does not require hours of manual review," says Sammartano.

A simple spreadsheet

Patient access leaders at Ochsner Health System in New Orleans developed a simple productivity Excel spreadsheet that uses a blend of recommended productivity key performance indicators (KPIs) from the National Association of Healthcare Access Management (NAHAM) and the Healthcare Financial Management Association (HFMA) for hospital, clinic, and ED registration. *[A* Sample Patient Access Services Monthly Productivity Log *is included with the online issue. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

"Because our organization operates some areas differently, we have adjusted these to meet what we feel is our target productivity, based on other KPIs such as QA and first claim payment rate," says **Stacy Calvaruso**, CHAM, assistant vice president of patient management. "We feel that you must balance quality with quantity."

For example, registrars are also receptionists in some rural clinics, which negatively affects the number of clinic visits per registrar. "Therefore, registrars' overall previous two-year performance by quarter is evaluated, and targets are adjusted accordingly," says Calvaruso. ■

MSP mistakes can cost millions in revenue -- Staff must understand meaning of questions

Most errors involving Medicare as a Secondary Payer Questionnaire (MSPQ) can be attributed to two things, according to **Kevin Willis**, director of Medicare Services in the Harrison, OH, office of Claim Services, a document retrieval company. Willis is a former Medicare Secondary Payer auditor.

These two items are emphasizing speed over accuracy and "taking dictation rather than conducting a patient interview," says Willis.

Accuracy often is sacrificed to expedite the registration process, with patient satisfaction in mind. "For the average patient, the longer it takes to conduct the intake interview, the less they enjoy their registration experience," notes Willis.

Potential mistakes with MSPQ

range from simply missing a retirement date to missing patient and spouse employment and group health plan coverage that is primary to Medicare, says **Elizabeth Reason**, MSA, CHAM, director of patient access for Cleveland County HealthCare System in Shelby, NC.

"Liability situations may be complex," says Reason. "These usually require additional documentation, as well as patient education in terms of how liability is handled by Medicare."

Delayed or lost payments

The goal of MSPQ is "to get the right information on the questionnaire before the claim goes out the door," says Reason. "Medicare's goal is to make sure no one else is responsible to pay the bill."

Willis warns that if staff members capture the wrong information for MSPQ, or determine the incorrect payer order, "it will most certainly result in delays in payment of receivables." In addition, incorrectly labeling Medicare as the patient's primary insurance, or missing payers that are primary to Medicare, often costs facilities greater reimbursement.

"Failing to identify the proper, primary payer will result in incorrect payments, accounts improperly labeled closed, and loss of that money when the error is discovered by the party that improperly paid primary," says Willis.

He says that "potentially millions" in revenue are at stake, and he adds that receiving improper commercial payments primary to Medicare often results in that payer recouping its payment beyond the timely filing parameter for the Medicare program. "This will leave the hospital with no one from whom to seek reimbursement," says Willis. "Medicare is then no longer liable for payment; nor is the patient."

Staff members often simply read the questions to patients and note the responses. However, says Willis, an MSPQ is *not* meant to be used as a document to dictate the patient's response to the questions.

"The MSPQ is a tool to make staff aware of that which they need to elicit from the patient," he explains. "Staff must understand each question and be able to present them in a way that each patient fully grasps the meaning." (*See related stories on training approaches for MSPQ completion, p. 118, and how MSP questions can be complex, p. 119.)*

Break it down

Each question within the MSPQ must be "broken down to its essentials" and explained to staff members responsible for getting the answers, says Willis. No one should administer a questionnaire without a thorough understanding of each question's meaning and its impact, he emphasizes. "Compliance is at stake. The success of the revenue cycle is at stake," says Willis.

Patient satisfaction is also a factor. "No one enjoys being asked complex questions, particularly when being asked by someone that doesn't understand the purpose of the question or its importance," says Willis.

Reason says MSPQ errors are "first and foremost a customer satisfaction issue." Patients receive multiple statements from medical providers, as well as the explanation of benefits from Medicare and other payers. "All the paperwork can become confusing. MSP errors compound that confusion," says Reason.

SOURCES

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EXECUTIVE SUMMARY

Incorrectly labeling Medicare as the primary insurance, or missing payers that are primary to Medicare, often costs facilities greater reimbursement and puts hospitals at risk for audits/fines. To avoid problems with the Medicare as a Secondary Payer Questionnaire:

- Don't sacrifice accuracy for speed.
- Ensure staff members understand the purpose of each question.
- Present questions so that patients fully grasp their meaning.

Patient access leaders can use these strategies for Medicare as Secondary Payer (MSP) training

Elizabeth Reason, MSA, CHAM, director of patient access for Cleveland County HealthCare System in Shelby, NC, has two goals with Medicare as Secondary Payer questionnaire (MSPQ) training.

"Not only do I want the patient access staff to get the right information documented on the MSPQ; I want them to be able to explain it to the patient in layman's terms," she says. Reason uses these approaches for training:

• She encourages staff to learn about Medicare, Coordination of Benefits, and MSP from the patients' perspective.

"Learning about Medicare from a patient's perspective drives home how important it is for us to get the bill right so the organization can receive reimbursement timely," says Reason.

It also helps staff members understand the patient's perspective. Reason asks her staff to read the following Medicare bulletins, all available on the Medicare.gov website: *Medicare and You* (http://1.usa.gov/1w7EBXi), *Medicare and Other Health Benefits: Your Guide to Who Pays First*, (http://1.usa.gov/1s2tITy) and *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* (http://1.usa.gov/WyterC).

"It is easy for us to get technical and use revenue cycle terms, but patients deserve a response in terms they can understand," says Reason. "Reading these bulletins helps us translate that message into patient-friendly terms."

• She educates staff continually.

"Annual re-education is important," says Reason. Staff obtain online education and validate competency by taking a quiz. "Regular education during staff meetings is also important," says Reason. "It generates discussion and reinforces concepts through staff experiences."

• She asks staff members to share MSP scenarios, and she uses these case studies at staff meetings.

"End-stage renal disease scenarios can be confusing, so it is important to mix a few of those into the case study approach," Reason says. Calculating the coordination period for beneficiaries eligible for Medicare due to end-stage renal disease who have group health coverage is a significant challenge itself.

Another training scenario involves a patient with group health insurance, who has a transplant, and who has to start dialysis again after 36 or more months. "If group health insurance is involved, the 30-month coordination period starts all over aagain," says Reason.

Training needs to address how liability situations impact Medicare beneficiaries and how to educate patients on the information needed to file the medical claim appropriately. "This is especially difficult when the injury occurred at a family or friend's house," says Reason. "The Medicare beneficiary has to request the family member or friend file a homeowner's claim."

VA cases also can be problematic, because the beneficiary needs to choose whether the service is VA-related or Medicare-related. "Unfortunately, personal preference can play a role in VA cases," says Reason. "This further complicates primary payer assignment, which can result in claim payment delays."

All completed MSPQs are audited at Children's Hospital Medical Center in Cincinnati, **Kristy Fazzio**, quality control auditor for registration services, looks for missing or incorrect items, such as the patient's commercial insurance coverage identified as the employer group health plan, or incorrect indication of whether the coverage is through a current or former employer.

In some cases, Fazzio contacts the patient or family for missing information, such as a spouse's retirement date. "You can complete the MSPQ without entering the data. The registration will let you skip over certain answer fields," she explains. "So staff don't always realize that it necessitates a response," she says.

The Contract Management & Compliance Office is asked to audit a sampling of the MSPQ audits completed by Registration Services. **Patrick Burke**, training and quality control auditor for registration services, says, "We ask them to look at what we do, and they verify that we are passing back correct information to staff. Partnering with them has vastly improved the quality of the MSPQs."

For example, the compliance office reported that for some MSPQs, patients went off Medicare at some point after their visit, so the MSPQ information for that date of service audited by the Contract Management & Compliance Office could not be verified as correct. "While registrars in the transplant clinic see MSPQs every day, registrars working in an ENT clinic may only see these once a year," says Burke. These registrars can call a newly implemented registration hotline, staffed by four trainers and quality control auditors. ■

Simple-sounding question is actually complex — Reading questions aloud is `poor approach'

Although it is possible to keep training on Medicare as Secondary Payer (MSP) fairly simple, "there are times when you need to stop, think, and ask a lot of questions," says **Elizabeth Reason**, MSA, CHAM, director of patient access for Cleveland County HealthCare System in Shelby, NC.

For example, the question "Are you actively employed by an employer of 20 or more employees?" seems very straightforward. Often, it is, but the following hypothetical scenarios can complicate things, says **Kevin Willis**, director of Medicare Services in the Harrison, OH, office of Claim Services, a document retrieval company. Willis is a former Medicare Secondary Payer auditor.

4 focus areas

Willis developed a two-hour training session devoted solely to these scenarios:

• The patient is on long-term disability and has not retired, or is on short-term disability and has not retired.

"The solution to understanding the actively employed aspect is to understand the federal definition of 'actively employed,'" says Willis. An actively employed person remains on an employer's payroll, he explains, and their income is subject to Federal Insurance Contributions Act (FICA) tax.

"Short-term disability surrounds remaining on the payroll. Long-term disability is akin to an insurance payout," says Willis. "One is employed, one is not, and the patient can't be relied upon to know the difference."

• The patient retired after 30 years on the job but is now working part time as a greeter at a major superstore store chain.

"A greeter at the local department store is on a payroll, and most likely that payroll contains 20 employees or more," says Willis. "They are actively employed, despite having an actual retirement date."

• The patient is under 65 and works for an employer of 30. However, that employer is party to a multi-group plan, and within that plan resides at least one employer of 100 or more.

"Number of employees" within a multi-group plan is measured by the employer within the plan that has the greatest number of employees. "Perhaps a better way of saying it is that if one employer within the plan meets the number criteria, then all meet it," says Willis.

For example, if a two-person team of a physician and his wife run the entire practice, there are only two employees. However, because they are part of a multi-group plan that has one practice well over 100, the two-person team meets the criteria for an employer of 100 or more.

• The patient hasn't been to work in 20 years but owns his or her own company.

"They held themselves a retirement party 20 years ago but remain on the payroll to glean profits," says Willis. If the company owners leave themselves on the payroll, then they remain actively employed. "Folks get caught up in the semantics game with words like 'retired,' 'working,' or 'employed.' These words mean different things in different contexts," he explains.

Know the reasoning

The above question isn't unique, says Willis. *Every* question on the Medicare Questionnaire poses its own points of confusion within the registration process.

"This 'rabbit' hole may seem deep, but it is not as deep as some other questions, particularly the accident-related questions," Willis notes.

Members of the patient access staff are more likely to give a correct response if they understand the reasoning behind a particular question. "The questionnaire advises what information is required to bill the Medicare program. It cannot be read aloud to patients to achieve high levels of success," says Willis. For example, the questionnaire will literally ask a 25-year-old on disability, "When did you retire?"

"In some cases, simply reading questions to patients is not just a poor approach to fact-finding," says Willis. "It is also bad customer service." ■

COMING IN FUTURE MONTHS

- Dramatically boost collections with patient portals
- Avoid lost revenue with medical necessity requirements
- Save costs by cross-training patient access staff
- Update metrics used to assess patient access staff

ICD-10 transition date finalized for October 2015

The Centers for Medicare and Medicaid Services (CMS) has announced that the final deadline to comply with the ICD-10 implementation requirement is Oct. 1, 2015, according to the National Association of Healthcare Access Management (NAHAM). The 10th edition of the International Classification of Diseases (ICD) is widely viewed as a significant change in the way claims that are submitted to Medicare and private insurance payers are classified.

These changes enable providers to coordinate patients care over distance and time, improve the accuracy of patient records with more detailed patient history coding, and reduce fraudulent claims. CMS leaders also believe that the ICD-10's granular classifications will improve the data and analytics related to public health research, surveillance, and reporting. The more specific classifications found in ICD-10 represent the evolution of diagnosis and developments in medicine and technology.

CMS released an online resource designed to help providers in small practices make a timely transition to ICD-10. The "Road to 10" is an online resource available at http://www.roadto10.org. The Road to 10 allows providers to select a profile based on their expertise that is specifically tailored to each speciality's common codes, clinical documentation procedures, and clinical scenarios. Additionally, the Road to 10 gives physician groups the opportunity to create an ICD implementation action plan specifically suited to the needs of their small practices. Go to: http://www.roadto10.org/action-plan/get-started. ■

Guide helps hospitals engage patients, families in their care

Research shows that when patients are engaged in their care, safety and quality can improve measurably. To assist, the Agency for Healthcare Research and Quality (AHRQ) has developed the *Guide to Patient and Family Engagement in Hospital Quality and Safety*, an evidence-based resource to help hospitals work with patients and families.

The free guide includes four elements:

• **"Communicating to Improve Quality"** helps improve communication among patients, family members, clinicians, and hospital staff members from the point of admission.

• **"IDEAL Discharge Planning"** helps reduce preventable readmissions by engaging patients and family members in the transition from hospital to home.

• **"Working with Patients and Families as Advisors"** shows how hospitals can work with patients and family members as advisors at the organizational level.

• **"Nurse Bedside Shift Report"** supports the safe handoff of care between nurses by involving the patient and family in the change of shift report for nurses.

The guide is available at http://1.usa.gov/18UDJ98. ■

HOSPITAL ACCESS MANAGEMENT™

Patient Access Services
Monthly Productivity Log
2014

Goal		
	ED	15-20 ppd
	ADMIT	30-35 PPD
	Clinic	55-60 PPD

ED

Months	Number of days	Productivity hours ED (from EPSI)	Reduced Non Prod Hours	Actual Prod Hours	volume	FTE count	Daily Reg Avg per FTE
January	31	2852.00	570.40	2281.60	4,577	9.20	16.05
February	28	2824.60	564.92	2259.68	4,057	10.09	14.36
March	31	2822.10	564.42	2257.68	4,920	9.10	17.43
April	30	2683.50	536.70	2146.80	4,782	8.95	17.82
May	31	2851.80	570.36	2281.44	4,701	9.20	16.48
June	30	2704.08	540.82	2163.26	4,430	9.01	16.38
July	31	2543.05	508.61	2034.44	4,595	8.20	18.07
August	31		0.00	0.00		0.00	#DIV/0!
September	30		0.00	0.00		0.00	#DIV/0!
October	31		0.00	0.00		0.00	#DIV/0!
November	30		0.00	0.00		0.00	#DIV/0!
December	31		0.00	0.00		0.00	#DIV/0!
							16.66

ADMIT

Months	Number of days	Productivity hours Admit/OP	Reduced Non Prod Hours	Actual Prod Hours	volume	FTE count	Daily Reg Avg per FTE
January	22	1128.00	225.60	902.40	3,756	5.13	33.30
February	20	1133.00	226.60	906.40	3,457	5.67	30.51
March	21	1280.20	256.04	1024.16	3,908	6.10	30.53
April	22	1402.61	280.52	1122.09	4,145	6.38	29.55
May	21	1307.13	261.43	1045.70	3,933	6.22	30.09
June	21	1284.27	256.85	1027.42	3,877	6.12	30.19
July	22	1229.21	245.84	983.37	3,952	5.59	32.15
August	21		0.00	0.00		0.00	#DIV/0!
September	21		0.00	0.00		0.00	#DIV/0!

October	23		0.00	0.00		0.00	#DIV/0!
November	19		0.00	0.00		0.00	#DIV/0!
December	19		0.00	0.00		0.00	#DIV/0!
							30.90

Clinic							
Months	**Number of days**	**Productivity hours Clinic**	**Reduced Non Prod Hours**	**Actual Prod Hours**	**volume**	**FTE count**	**Daily Reg Avg per FTE**
January	22	2624.00	393.60	2230.40	20,535	12.67	73.65
February	20	2616.00	392.40	2223.60	15,317	13.90	55.11
March	21	2492.30	373.85	2118.46	12,547	12.61	47.38
April	22	2706.32	405.95	2300.37	12,502	13.07	43.48
May	21	2962.57	444.39	2518.18	12,586	14.99	39.98
June	21	2423.70	363.56	2060.15	11,862	12.26	46.06
July	22	2693.02	403.95	2289.07	13,476	13.01	47.10
August	21		0.00	0.00		0.00	#DIV/0!
September	21		0.00	0.00		0.00	#DIV/0!
October	23		0.00	0.00		0.00	#DIV/0!
November	19		0.00	0.00		0.00	#DIV/0!
December	19		0.00	0.00		0.00	#DIV/0!
							50.40

Source: Ochsner Health System, New Orleans.