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INSIDE

DECEMBER 1999

VOL. 18, NO. 12 (pages 133-144)

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Challenge of getting MSP answers sparks computer, training solutions

HCFA gives rave reviews to Portland system; now it's a model

Imagine being told after an audit by the Baltimore-based Health Care Financing Administration (HCFA) that your organization has a "very pristine process" for filling out the Medicare secondary payer (MSP) questionnaire, and there is probably no need for audits at your system's other hospitals.

That's exactly what happened at the Providence Health System in Portland, OR, says **Barbara Wegner,** CHAM, regional director for access services. In fact, Wegner adds, the auditor asked if the process at Providence could be shared with other health care providers struggling to comply with HCFA's stringent guidelines for determining if there is another payer who should be primary when a Medicare patient receives medical treatment.

Failure to show that registrars have thoroughly questioned patients regarding whether Medicare should pay the bill can result in fines for each violation and ultimately could cause a facility to lose Medicare eligibility. The False Claims Act, which can come into play any time providers seek improper reimbursement, provides for fines of up to $10,000 per incident.

The positive results at Providence didn't come easily, says **Kellie Friderick,** quality assurance and training analyst, who worked closely with access staff after Providence Milwaukee hospital, located in a Portland suburb, was given two months' notice that its MSP procedures would be examined. The hospital was told to prepare for an on-site audit that would include interviews with staff and a random inspection of 60 Medicare claims, Friderick adds.

"For the past year, we had been trying to bone up on the gathering of information for the MSP form, so we had a lot of documentation and a lot of training materials," she says. "For the two months before the audit, we focused very heavily on preparing that facility." **(See related story, p. 135.)**

As it happened, the installation of a new set of MSP computer screens coincided with the audit preparation, so training was incorporated into the process, she says. "Our software vendor, [Atlanta-based] McKesson-HBOC had built a new MSP page to comply with the new Medicare regulations that came down in February."

The new computer screens were very different from the two-page computerized MSP form staff had worked with before, Friderick says. "The new system is very much driven by the Medicare regulations and the way they ask the questions. Depending on the answer on one page, there may or may not be another screen flow. Based on patient response, there will be up to five different screen flows [the registrar] may encounter."

The new regulations require that three more MSP questions be asked:

1. Are the services to be paid for by a government program such as a research grant?
2. Have you received a kidney transplant?
3. Have you received maintenance dialysis treatments?

For end-stage renal disease, one of the other conditions mentioned in the MSP questions, "it gets very involved with coordination of benefits and issues surrounding dual entitlement — if there is an employer group plan," Friderick adds.

During the Providence Milwaukee visit, the HCFA auditor met with the on-site access services manager, the compliance coordinator, and Friderick. "She asked basic questions about training and how often we were asking [the MSP questions]," Friderick says. The answer was that we do it on all admissions and outpatient visits. We presented her with our policy, training material, attendance sheet — quite a stack of material — and talked her through it."

The staff left the auditor alone to examine the 60 patient accounts that had been randomly pulled, Friderick says, and then took her to the registration area, "where she asked registrars some pointed questions" about how they handle different patient scenarios. Although no Medicare patients came through the admitting department during that period, Friderick notes, the auditor later was able to observe an emergency department registration of a Medicare patient and follow up with questions.

The exit interview went well, she adds, with the auditor noting that "ours was a very pristine process, as far as the documentation and the audit. She asks us a few questions about the accounts, and we were able to get those answers." One computer-related question had to do with how the data from the patient demographic page pulled forward onto the MSP page, Friderick says, and another with how registrars handle the interview if they suspect the patient may have been in an accident.

"When we interview any patient, if any diagnosis leads us to believe there was an accident, or if there are bumps or bruises, the staff will ask the patient if this is the result of an accident," she explains. "If the patient fell, we ask if it happened at home, in which case Medicare is responsible. If it happened at the grocery store, we would follow that with more questions. It's a big challenge to gather some of this information."

Storing MSP records can be 'nightmare'

HCFA requires that health care organizations keep for 10 years documentation showing they have asked patients the MSP questions, notes **Karen Dufty,** CHAM, director of patient services for Meritcare Health System in Fargo, ND.

"If your software company can't build in screens so you can store that information, it's a real nightmare," Dufty says. "You have to make sure you print [the document] and keep it in a paper file, and you have to ask the questions every single time."

Working with its software vendor, Malvern, PA-based SMS, and outside consultants, she adds, Meritcare addressed that part of the MSP nightmare last spring by building into the registration screens all the questions Medicare requires.

"If the registrar just keeps flipping the screens, [the computer] will ask them a question and, depending on how they answer, will immediately take them to another question," Dufty says. "If

the patient answers 'yes' to the question about being treated for black lung disease, it automatically brings up another set of questions. If 'no,' it won't bring those up."

Dufty advises making the process as easy as possible for registrars. "Have a good screen flow, so they don't have to think about [the next step]."

Although the software solution is working smoothly, it doesn't change the fact that patients must be asked the same questions again and again, Dufty says. "Do patients appreciate us asking those questions? No, they really don't, but we tell them it is a requirement, so they don't blame us."

The process is particularly onerous for outpatients, many of who come in for regular visits, she points out. "We have a cancer center, and when those patients come in for treatment, we have to work with caregivers as to why we burden patients who are receiving radiation with these questions."

Despite the frequency of visits, outpatients must, according to HCFA regulations, be asked the MSP questions each time. One of her organization's focuses, Dufty says, has been to make sure "there is not a single area for any service" that fails to do so.

Caregivers are understandably concerned, she notes, when patients complain, for example, "I come in every week, and every time they ask me about this black lung disease."

In addition to educating clinical staff on why the questions must be asked, she says, her facility is experimenting with handling the procedure in a different way. "I think someone like access representatives or registrars, who understand the background, needs to ask the questions," Dufty adds, "because some have to do with whether the spouse is working or whether the spouse has insurance coverage. But there might be a slightly better place or time."

One idea, for example, is to have the patients sit down in the waiting room and let the registrar go to them, rather than have them standing in line or at a desk to answer the questions, she says.

The question of how to meet the MSP requirement when a patient comes in unconscious or incoherent has providers scrambling for answers.

In researching this issue for several institutions in the Northeast, **Claudia Hinrichsen,** a health care attorney with Nixon, Peabody, LLP's Long Island (NY) office, informally surveyed access managers across the country. The responses varied from hospital to hospital, but one central theme is significant, she says. Hospitals must make diligent efforts to obtain information in order to complete the MSP questionnaire.

"Attempts should be made to contact spouses or next of kin," she says. "If the patient is unconscious upon admission, make sure there are efforts to go up to the floor when the patient regains consciousness. If the patient comes from a nursing home, call back to the nursing home to get this information. The key is that the institution thoroughly document all efforts to obtain the information."

If access personnel have exercised all reasonable efforts and are still unable to answer all MSP questions, they should document those efforts and explain that they were unable to obtain the additional information, Hinrichsen adds. ■

One-on-one MSP training prepares staff for audit

When Providence Milwaukee, a suburban Portland, OR, hospital that's part of Providence Health System, was notified that its Medicare secondary payer (MSP) process would be audited by the Health Care Financing Administration (HCFA), access services and training staff went into high gear.

In preparation for the audit — for which the facility received two months' notice — members of the system's regional quality assurance (QA) and training staff went to the targeted hospital and worked closely with access employees, says **Kellie Friderick,** QA and training analyst.

Analysts manually audited the MSP page for every Medicare patient that came through the hospital during a three-week period, Friderick says, and gave feedback on each account to **Patricia Weygandt,** the on-site access manager.

"Every day, we would get e-mail from the [internal] auditor outlining MSP errors," Weygandt explains. "I would look up each [account], go to the individual registrar, and walk through the process. Because it was so fresh — work from the day before — we could talk about what their thinking had been, why they had done what they had done. It was very helpful."

Two days before the actual HCFA audit, Weygandt says, a special session was held with staff who would be working that day. "They would

draw a number that signified a particular patient scenario and, in a group setting, sit at the computer and go through the interview." Then the group would discuss that registrar's choices, Weygandt adds.

In other session, Friderick notes, "We demonstrated how to ask the questions and how to phrase them to get the optimum information from the patient."

As part of the preparation, Friderick says, trainers made sure employees were very clear on the meaning and purpose of each MSP question. "We talked about the expectation if the auditor were to sit down with them and ask questions and tried to make them as comfortable as we could." ■

Access employees bloom, thanks to support system

Better raises, happier patients are by-products

Access management employees are being empowered and patient satisfaction scores are rising, thanks in large part to an operational support program in place at Rex Healthcare in Raleigh, NC, says **Sammie Best**, CAM, executive assistant to the vice president of network services.

The Rex Operational Support Association (ROSA), which offers continuing education and other professional support to access employees and other nonclinical personnel, was established in April 1997. Since that time, the health care system's scores on the Princeton, NJ-based Gallup Organization survey have risen to the point that the point scale had to be realigned, says Best, who until late September was manager of inpatient registration. "We've stayed above the North Carolina average and the national average," she says. **(See charts, p. 137.)**

ROSA also is largely responsible for Rex's recognition by *Working Mother* magazine for the third consecutive year as one of the 100 best places for working women, she notes.

The impetus for ROSA, which has grown from about 200 members to 730 since its inception, was the need for more opportunities for support personnel, says **Elaine Vasques,** corporate executive assistant at Rex Healthcare. "Historically, health care facilities have always provided support and continuing education for clinically oriented staff members," she adds. "This organization has begun to think differently."

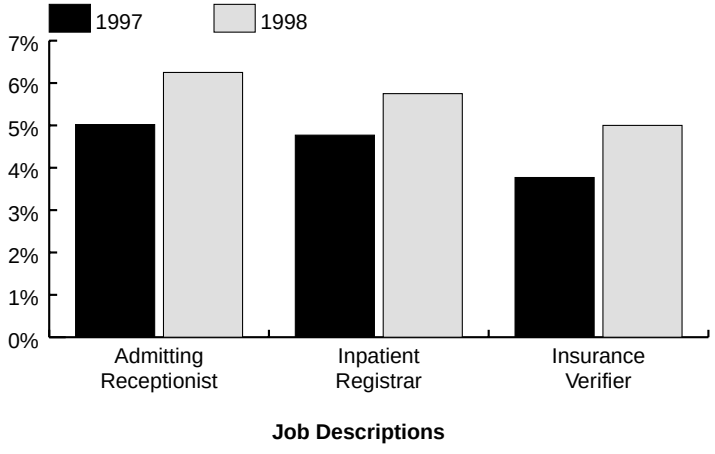
There are no dues or other membership requirements associated with ROSA, she says.

At the outset, notes Vasques, who chairs ROSA's executive committee, its organizers came up with three goals: education, communication, and integration. "Communication and integration almost go together," she says. In an integrated health system like Rex Healthcare, which includes a 388-bed hospital, a 56-physician primary care network, a home health service, and a number of other major treatment centers, "people tend to get territorial, which causes problems," Vasques adds. "Our ultimate goal is to integrate our membership so that employees in primary care know those in materials management; to break down those walls."

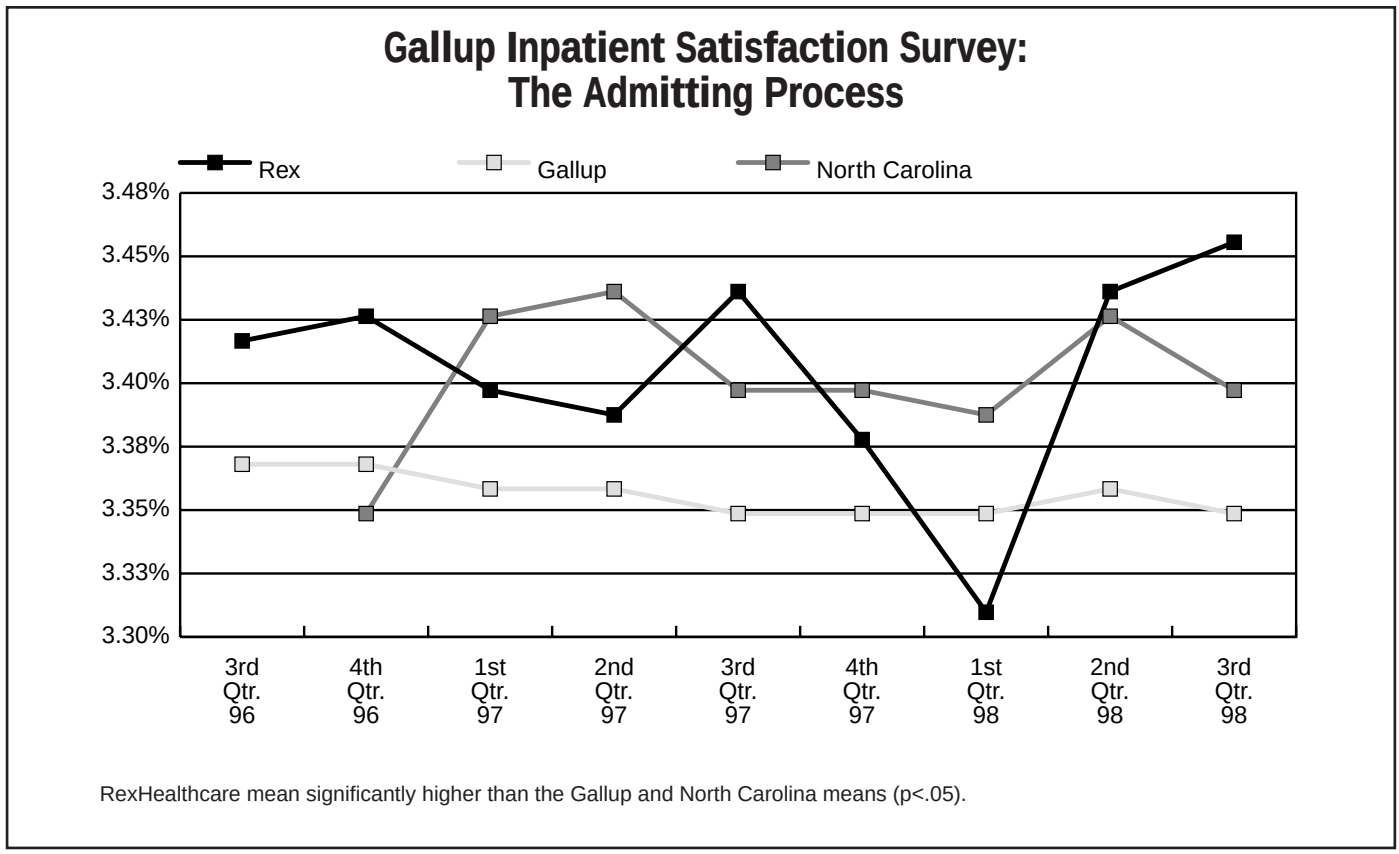
ROSA's executive committee, which meets monthly, is made up of 18 people from throughout the organization, she says. A number of subcommittees also meet monthly, and there are quarterly membership meetings. "We have motivational speakers, luncheons with management staff, and fun fairs with lots of games," Vasques says.

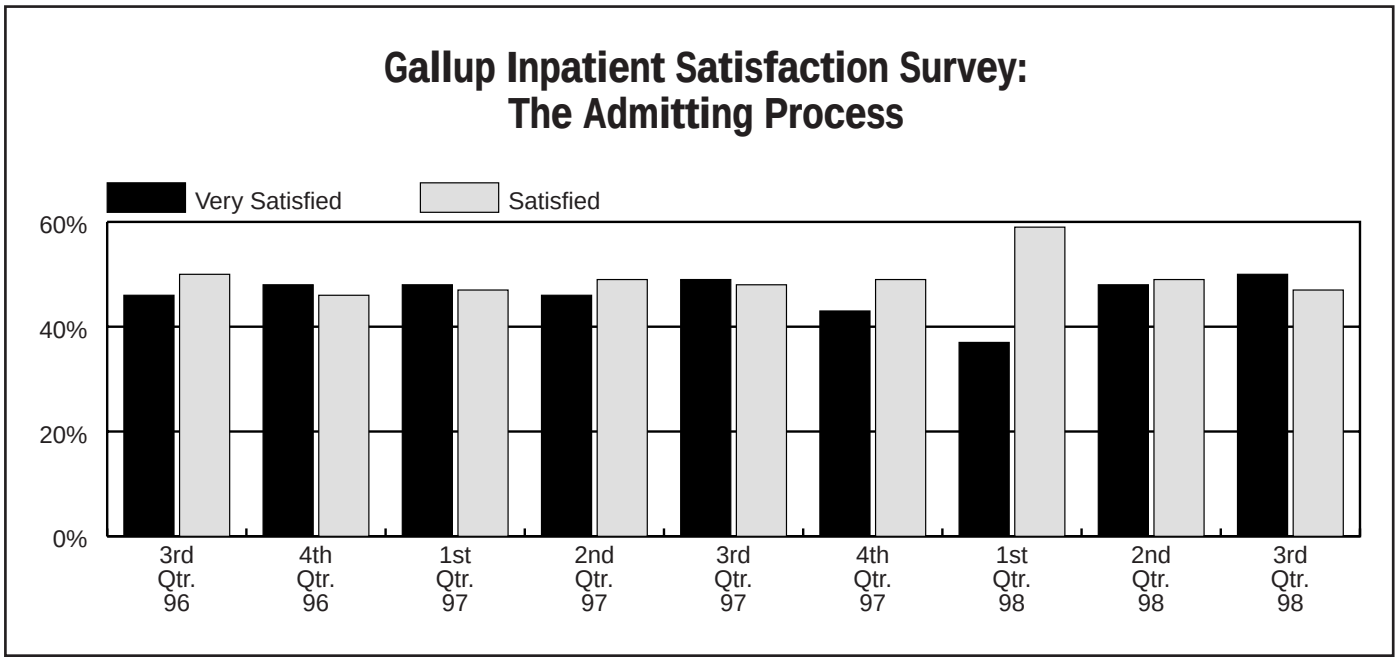
A recent event raised money for a scholarship fund that benefits members pursuing education in nonclinical areas, she adds. That fund, which is in the midst of its first application process, will award scholarships for spring quarter classes.

Every quarter, ROSA sponsors one major educational offering, Vasques says. Past topics have included business writing, dealing with difficult



Source: Charts on pp. 136-137 are courtesy of Rex Healthcare, Raleigh, NC.





people, and professionalism. There also is specialized computer training for support staff, she notes, in acknowledgement of the fact that "not everybody does everything."

Members of the Rex education and development staff and trainers from the information technology division provide instruction, "and when we need outside help, we bring in consultants and educators," Vasques adds.

One of the keys to ROSA's success is the backing of Rex Healthcare's president and chief executive officer, whom organizers approached for support at the outset, she notes. "We went from the top down. We outlined the idea, and he wholeheartedly supported us from the very beginning, offering a budget for ROSA from his own budget."

Those funds, Vasques adds, pay for special

Need More Information?

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events, employee incentives, and travel for ROSA members who take advantage of outside educational opportunities or represent the organization at various professional gatherings, such as last spring's National Association for Healthcare Access Management conference.

Best, who fostered ROSA's development while manager of inpatient registration, says the program was her avenue for improving the low scores on the annual Gallup survey, which measures patient satisfaction. Over the past five quarters, she adds, those scores have risen continually.

ROSA helped boost those scores — leading to annual merit increases for access services staff — by creating better access employees, says Best, who is a member of ROSA's executive committee and also serves as historian. **(See chart, p. 136, for details on the merit increase.)**

"Overall, they've become such well-rounded individuals in their communication with the public — their customer service skills," Best says. Through ROSA's special events and continuing education opportunities, access employees "feel totally involved," she adds. "We're not letting them get stale."

Not a requirement to belong

Access employees are not required to be part of ROSA, "but we didn't have many that didn't want to participate," Best says. "There's always something new, fun, and creative to participate in. They were ready for a change."

In her new role, Best points out, she interacts with Rex's primary care physicians, bringing the message of ROSA to a broader access audience. "If you think about access, it comes in many forms; not just inpatient services, but anywhere a patient comes into the organization, including primary care facilities."

In line with that all-inclusive philosophy, staff from the primary care practices sit on ROSA's executive committee, she adds.

Before developing the program's educational offerings, ROSA's leadership did a formal needs assessment of all members and surveyed management staff for their perception of those needs, says **Carolyn Holloway,** RNC, CAN, MSN, director of education and development. That process, she notes, identified mostly needs that directly related to access services.

Skills identified as needing improvement were:

- professionalism;
- business writing;
- leading meetings;
- taking minutes;
- computer skills;
- phone skills / customer service.

Each of those needs has been addressed through continuing education, Holloway says.

The effect on the access services staff has been dramatic, Best adds. To make those kinds of changes, she says, "the staff needs empowerment. You can give them this through involvement. If they have the tools to learn, they grow." ■

Train reps to have a business mentality

Encourage them to assume larger responsibilities

Are your access services representatives monitoring just their registration cubicles, or are they also checking out the entire waiting room? Does your department keep statistics on incidents involving illegal aliens and closely question police when they bring in injured suspects? How about attempting to get an address — even if it's just a street corner — for that homeless person who shows up in the emergency department every Saturday night?

The answers to those questions often distinguish an average access department from a good one, suggests **Jack Duffy,** FHFMA, corporate director for patient financial services at Scripps-Health, San Diego. The key is the ability to set up complete cycles in handling patient encounters, rather than starting over each day and closing the door at 5 p.m. on everything that happened in between, Duffy contends. He says it can make a difference in your organization's bottom line.

"We in access are so episodic in our thinking," he says. "History is what happened last night. It's that mentality of incompleteness."

In San Diego County and other areas on the U.S. border, it is generally the policy of the U.S. Border Patrol not to take custody of injured people who need emergency care, thus avoiding responsibility for medical charges, according to a 1997 report by the California Bureau of State Audits.

As a result, San Diego County health providers incur millions in unauthorized emergency medical treatment to unauthorized immigrants, the report states. **(See related story, p. 140.)**

The typical response of access services, Duffy points out, is to say, "It happens," and realize those unpaid charges will fall into the category of bad debt. Instead, he says, "the access manager on the front line has the primary responsibility to report these incidents, not blend them into the global debt. If things are ever going to change, it will be because statistics are kept."

The answer is accountability

If a police officer comes in saying he's acting as a good Samaritan with a suspect who has five bullet holes, the access representative is well-advised to seek further information, Duffy says. "The answer is accountability. Get the name of the person who brings in [the injured person]. Was he accompanying the patient in the ambulance? What is his name? His badge number?"

That way, he adds, when the hospital sends a bill to the county or to the sheriff's department, it can better illustrate a custodial relationship as opposed to a friendly ride to the emergency department (ED). In some instances, the access rep may need to go the extra mile, extending the interview process to other witnesses. Getting the details may strengthen the hospital's position, Duffy says, as in, "If you were beating this guy up, we think that qualifies as his being in custody."

In the case of the Border Patrol and unauthorized immigrants, much of the value of documentation may be for its later use in supporting political change, he adds. "The state of California sued the federal government and said, 'An unsecure border is your problem, and you should be paying,'" Duffy points out. "It still is a national issue."

Gathering statistics and taking them through the bureaucracy to the decision makers is how policies change, he adds. "If it all goes under global bad debt, it doesn't get solved."

One strategy for getting payment from illegal aliens, Duffy says, involves pushing a little harder for identification. "[The unauthorized immigrant] may give his brother-in-law's address, so ask for a picture ID," he suggests. A couple of extra questions may establish that the patient's permanent address is Tijuana, Mexico, Duffy notes.

Assume you'll never see them again

After triage, when questions about finances are allowed, he suggests asking the uninsured person how he will pay for the medical care. "At Scripps-Health, we've attempted to set up procedures that assume this is the last time we'll see that person," Duffy says. In some cases, he adds, registrars will tell the uninsured patient who has been brought in by friends or family, "Go out and collect $20 from every person in the car. That's your charge for the night."

If studies show that certain groups never pay their bill, realize that "if we ever get paid, it's going to be tonight," Duffy says. Too often, he adds, providers "build in" a certain amount of bad debt without considering innovative ways to reduce it.

Most patients don't come in unaccompanied, Duffy points out, thus the question, "Are you monitoring just your registration cubicle, or are you monitoring the waiting room? The cash is in the waiting room. Who has arrived and what can they do to improve the amount of information you obtain or the funds you solicit?"

This philosophy also works well in the area of automobile accidents, he notes. If your patient was not at fault, then knowing things about him or her brings limited success in collecting payment, Duffy says. "What is the insurance of the driver of the other car?" Since coverage amounts are usually capped and funds are paid on a first-come, first-served basis, time is of the essence, he adds.

Get in line first

What's important, Duffy notes, "is knowing that it was Lucy's car that rear-ended [the patient's car] and that she has insurance with State Farm, and where to send the bill." Also waiting for payment are the ED physician and the ambulance service, and if the hospital doesn't get in line first, he says, the result may be more bad debt. "It's very competitive, and it's happening right there," Duffy adds. "It's not something

Access records may help recover $2.9 million

Records document Border Patrol abuse of law

San Diego County health care providers incurred more than $2.9 million in unreimbursed charges for emergency medical treatment involving unauthorized immigrants and the U.S. Border Patrol between January 1996 and May 1997, according to a 1997 report by the California Bureau of State Audits.

Those charges were associated with 199 incidents involving injured unauthorized immigrants and Border Patrol agents who arrived at the scene either at the time the injuries were discovered or soon after, the report states. "In all cases, Border Patrol agents had an opportunity to assess whether the injured were unauthorized immigrants and whether to take them into custody — either immediately or following medical treatment," the report continues.

Health care providers are adversely affected, the report explains, by the Border Patrol's seemingly illogical policy of paying the emergency care charges only for unauthorized immigrants already in its custody at the time of treatment. It is the Border Patrol's policy not to take injured suspects into custody because they are "unlikely to escape."

The report questions the logic of that policy, pointing out that although injured suspects may be deemed unlikely to escape and thus avoid immediate apprehension, this status appears temporary in most instances.

"Given that in over 70% of the incidents we analyzed, the suspects were treated on an outpatient basis," the report continues, "it seems logical to have some form of prompt follow-up contact to reconsider custody." Instead, the report quotes a Border Patrol spokesman as saying an agent "generally does not make hospital calls" unless the patient was already in custody or "under suspicion."

"We believe," the report concludes, "that if suspects' injuries were the only reason they were not taken into immediate custody, then all such people should be considered 'under suspicion.'"

Actual unreimbursed charges for such cases, many of which were not identified, are likely much higher than $2.9 million — amounting to another $2 million to $5.2 million — the report estimates.

Closely monitor and document

Similar situations exist in other border areas, suggests **Jack Duffy,** FHFMA, corporate director for patient financial services for ScrippsHealth in San Diego. Those situations present an opportunity for access managers to make strides toward getting better reimbursement for their organizations.

Closely monitoring and documenting incidents involving illegal aliens could help lead not only to more reimbursement in the short term, but also to beneficial political changes, he says.

"[City or state officials] might be hesitant to rock the boat if they think something is an isolated incident," Duffy says, "but if you can show that it happened 23 times and cost $160,000, that's another story." ■

the business office can manage correctly."

At ScrippsHealth, four out of five pieces of returned mail are related to ED registration, Duffy points out, which leads to the question, "What are your policies on transients?"

When registering a patient without a real address, he says, ask pointed questions to find out how to locate that person if necessary. "Find out what the person's 'route' is," he suggests. "Ask, 'Where do you stay? What corner are you on? How do I get a message to you?'" Consider, Duffy says, that you might be able to get medical assistance funding for the person if you take the time to gather this information.

Noticing, for example, that the same homeless person comes in every Saturday night for treatment means that next Saturday night you could have an application for medical assistance ready to be completed, he adds.

"Do you have blinders on," Duffy asks, "and just see the person in front of the bullet-proof window for five to seven minutes, or do you really try to manage bad debt? Those with breakout thinking will do better." ■

Battling the BBA: Access has a role

Proper admitting diagnosis is key

As Congress looks at legislation to counter the devastating financial effects of the Balanced Budget Act (BBA) of 1997, providers struggle to comply with its dictates while continuing to give patients the care they deserve.

Access managers have an important role to play in ensuring their organizations' viability, say leaders in the access field and health care consultants charged with designing revenue-saving solutions.

"When the BBA was put in place, it was basically to restrict revenue," says **Mark Simonson,** a Minneapolis-based director specializing in institutional reimbursement with the consulting firm Deloitte and Touche. "When you have that, an institution has to respond, to develop strategies."

Hospital admissions more complex

What that means for access managers and their employers, Simonson says, is the "need to identify from an admission standpoint the type of patient they can accept in order to be able to provide services within that revenue."

Stand-alone rehabilitation and skilled nursing facilities (SNF), for example, can more easily identify the patients who will be too expensive to care for and not admit them, he adds. "Within a hospital, it gets more complicated" because many are "multi-providers" that operate SNFs and rehab units under a very large umbrella.

With the old system, hospitals got diagnosis-related group (DRG) reimbursement for acute patients and then continued to be paid when those patients moved on to an exempt unit, which received fee-for-service payments, Simonson points out. "What the BBA does is put pressure on all. There may be some patients that to the extent a provider has other alternatives, it may not want to admit to its own rehab unit anymore.

"The decision is not illegal evaluation or payer status," he adds, "but more an issue of organizing units to take care of the patients you can take care of."

As patients come in the door, Simonson suggests, the access manager should assess their needs. "It's the starting point for where you're ultimately going to fit the patient into the delivery system.

"To the extent the institution can provide better guidance to the services it provides, that needs to be communicated to the people at the front end," he says. "Alert the patient care manager or the case coordinator that there is something unique about this patient, that he or she will require special attention, and work harder to figure out where that care should be given. Be as clear as you can on admitting criteria."

Determine level at registration

Determining the appropriate level of admission — inpatient or observation — for a patient at the point of registration is more crucial than ever, notes **Jackie Birmingham,** RN, MS, A-CCC, CMA-C, a consulting associate for the Center for Case Management in South Natick, MA.

Physicians often write an order for an observation bed, but the patient is later admitted as an inpatient, she points out, meaning that hospitals may receive only the lesser reimbursement that accompanies observation status.

"Admitting personnel need to be conscious of what is the expected plan for the patient," Birmingham says, to the point of questioning physician orders that are not supported by the Health Care Financing Administration's criteria. "So much screening is done based on the admitting diagnosis," she adds. "When admitters get that information to put on the face sheet, they need to get a really good diagnosis."

Screenings may not be reimbursed

At one health care institution she has worked with, Birmingham notes, "the usability of the admitting diagnosis is not even 50%." In one case, she says, diverticulitis was the admitting diagnosis, but the patient had actually had a stroke. In addition to the obvious treatment concerns, such mistakes result in expensive screening that may not be reimbursed, Birmingham adds.

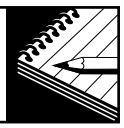
"There also could be a delay in discharge and a loss of money with the DRG," she says. "The value to caregivers of the information admitters collect upfront is just awesome."

One effect the BBA has had on access services, says **Beth Ingram,** CHAM, director of patient financial services at Touro Infirmary in New

Orleans, is to establish that precertification of scheduled patients is no longer just a desirable option, but a necessity.

"It has become more important to ensure that you have gone through the appropriate precertification and verification so you can limit your loss," Ingram adds. "It's critical that access managers have a process in place so their facility is protected for the service it is providing. There are a surprising number that don't do that. It can't be a 60% rate of preverification and preregistration. It has to be 100%." ■

GUEST COLUMN



Take leading role in contract process

Upfront access participation is key

By **Jack Duffy,** FHFMA
Corporate Director
Patient Financial Services
ScrippsHealth, San Diego

How many times have we as access managers been called by the business office regarding our failure to make the third "patient admitted" call, only to find out that the contract was changed six months ago?

This all-too-frequent occurrence is symptomatic of the lack of partnership between those who negotiate contracts and those who have to comply with an ever-changing contract environment.

For the most part, health care organizations sign contracts whose terms and conditions were prepared by the insurance company. These documents are written for the protection of the insurance company and often are full of restrictions that have a financial penalty.

There are several steps every access department should take to ensure the organization gets the best value for its contracts. They include:

1. **Volunteer.**

Be an active part of the contract committee. Go to the meetings and let your colleagues know what works and what doesn't work.

2. **Measure, measure, measure.**

Keep track of failed accounts and report to the contract committee each month. Most patient accounts systems establish a coded transaction for things like "administrative write-off" or "adjustment." Learn those codes and how they relate to access. There's often a very direct correlation between the complexity of the contract and the error rate.

3. **Network.**

Use your professional contacts to determine what works in contract construction. Discuss items in general terms and do not disclose prices. Report particularly onerous terms to your senior management and to the local or state health care councils.

4. **Just say no!**

If you believe a contract term is so difficult and complex that your department will often fail to comply, just say no. Lay out your objections in a logical way and make your case. A contract usually has dozens of terms that can be negotiated. Leave the ones that cannot be fulfilled at the table.

5. **Training.**

The key to a successful patient financial services function is training. The most important moment in an account's history is the point of service. Take the time to thoroughly train on every new contract. Each year, retrain the staff on the most common contracts and on any contract that has a significant error rate.

6. **Timing.**

This is another critical factor. As referenced at the beginning of this article, it is of little value to learn of a new contract six months late. Make it a departmental service standard that all contracts are reviewed by access *before they are signed.* It is relatively easy to change a poor term prior to signing, but try to find someone willing to reopen a contract after months of negotiations. The consequences of missing a review date could be years of frustration because of a poorly constructed contract.

7. **Reference material.**

There are times when we must believe that a photographic memory is required for access management. Look for innovative ways to share contract terms with the staff. At ScrippsHealth, we

are in the process of scanning 75,000 pages of contracts into the Intranet. This will allow six-second access to any page in our contracts. We also have created a CD-ROM for all contract summary pages. This allows items like co-pays and contact numbers to be only a mouse move away.

A few words about empowerment: As I work with access managers across the country, I often hear legitimate complaints about not having a voice in how policies and procedures are developed. While there is positive news in some organizations, the lack of participation is still too common. Meet with your chief financial officer and administrator frequently to offer your assistance in contract construction. Come prepared to show the financial advantages of well-thought-out contracts. Keep your commitment to measurement. After a few successful rounds, you will find yourself a trusted member of the contract team.

(Jack Duffy serves as consulting editor for Hospital Access Management.*)* ■

Teen program puts focus on confidentiality

Special billing practices used

"Sensitive Services," a program handled by access personnel at the University of California at San Francisco (UCSF) Stanford Healthcare, focuses on patient confidentiality.

Aimed at protecting the privacy of teen-agers seeking services they don't want their parents to know about, "Sensitive Services" is administered by the state through MediCal, California's version of Medicaid, says **Robin Hanson,** manager of registration services for UCSF Stanford's north campus in San Francisco.

Until late September, registration for the program took place in the main admitting area, but it is now done by administrative personnel at the facility's teen clinic, Hanson says. The registrars in the main admitting area, who handle some 200 registrations a day, she notes, "are more likely to remember how to do it."

After the teen-ager has been screened, but before provision of the service — which might be treatment for venereal disease or termination of pregnancy — he or she completes a MediCal application, she adds.

Then the patient is registered, Hanson says, with these important variations from the normal process:

- There is a special patient type code.
- No guarantor information is included.
- No insurance information is included.
- The mailing address is the hospital's accounts receivable department, to make sure the bill never gets out the door.

A weekly report is generated that includes all accounts with this patient type to make sure they have been done correctly, she says, and that no bills are inadvertently sent to a patient's home.

Once the application has been sent to MediCal and returned, the computer system is updated so the hospital can bill MediCal, Hanson says. "If MediCal denied coverage for any reason, the bill is written off, but I don't remember that ever happening."

Hospital Access Management™ (ISSN 1079-0365) is published monthly by American Health Consultants®, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Access Management**™, P.O. Box 740059, Atlanta, GA 30374.

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Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. One to nine additional copies, $319 per year; 10 to 20 additional copies, $239 per year. Call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $67 each. (GST registration number R128870672.)

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Despite the safeguards, there have been "a couple of slip-ups," she adds, in cases where the pediatrics clinic handled the registration. "About a year ago," Hanson says, "a mother came into the pediatrics department demanding to know what service her child had received."

An advantage to handling Sensitive Services registrations in the pediatrics clinic, on the other hand, is that the patient can stay in one place, Hanson says. "They don't have to shuttle back and forth. Since eligibility has to be renewed every month, it makes sense to have it all in one place." ■

ACCESS FEEDBACK

Is anyone saying no to uncooperative doctors?

Which access services departments are taking the proactive stance of not scheduling elective services for managed care patients without an authorization? That is the question posed by **Martine Saber,** CHAM, regional director of patient access services for Baycare Health System in Clearwater, FL.

The issue, she says, is that physicians, who are responsible for obtaining the authorization, often schedule elective surgeries that are not preauthorized. In fact, some physicians simply schedule blocks of operating time for several surgeries and don't identify the kinds of procedures being done until the day before, Saber adds.

Check with physician's office

More often, she notes, the problem is that a physician sends a patient with an aneurism, for example, to the hospital for a computerized axial tomography scan of the head. The hospital performs the procedure, which is obviously needed and shouldn't be delayed, and finds out later the physician has not gotten the preauthorization, Saber explains. The insurance company denies reimbursement, saying it should have been called in advance.

Even trickier, she points out, are cases in which a primary care physician (PCP) refers a patient to a specialist, who then tells the patient to schedule himself for a magnetic resonance imaging procedure. No one gets the preauthorization because the specialist says the PCP should do it, and the PCP responds that he didn't order the test, Saber says.

"Nobody wants to get it because of the time that's spent holding on the phone," she notes.

Saber says she would like to know what it takes to establish a ban on unauthorized elective procedures.

"How did [institutions that have instituted a ban] get to that point? How successful are they in doing this, and have they lost physicians as a result? Some hospitals are frightened to [ban unauthorized procedures], saying, 'We don't want to upset our physicians,'" she notes. "We're at the point of saying, 'We don't want this type of physician.'"

[Editor's note: If you have feedback for Saber, please call editor Lila Moore at (520) 299-8730 or send e-mail responses to lilamoore@mindspring.com. Saber may be reached at Morton Plant Hospital, 323 Jeffords St., MS#43, Clearwater, FL. Telephone: (727) 462-7139. Fax: (727) 461-8488.] ■

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