AMERICAN HEALTH CONSULTANTS®

FOR 19 YEARS

# Hospital Access Management™

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

April 2000 • Vol. 19, No. 4 • Pages 37-48

## IN THIS ISSUE



***In This Issue*** **continued on next page**



# Can it be true? Patient-focused care *and* savings

*Admitting comes down from the 'Mount'*

After taking $25 million out of its budget, eliminating 540 jobs, and, among other changes, closing the central admitting department, New York City's 1,200-bed Mount Sinai Medical Center is "a better functioning hospital," says **Joel Seligman,** MBA, MPH, vice president for patient services.

Registration now takes place in each of nine individual "care centers," part of a patient-focused care solution that Seligman says is kind to patients *and* the bottom line. "Even I underestimated how much it would mean to patients to have admission on the local level," he adds.

Because there is no physical admitting department, Mount Sinai created a function called "central listing" to oversee admitting activities between the hours of 11 p.m. and 7 a.m., Seligman says. Someone is available to assign beds, a necessity with an active emergency department that sees some 75,000 patients a year. Central listing also reports to management on length of stay and admitting and discharge information, and it arbitrates when there are no beds available.

There is no admitting director or manager. Instead, Seligman explains, each care center is run by a combination administrator / nursing executive. Those care center directors report to Seligman and the vice president of nursing, who jointly oversee all the centers, he adds.

Even before Mount Sinai began the five-year patient care re-engineering campaign in 1994, work had begun to overhaul the admitting department, notes **Patricia Garcia Sullivan,** RN, vice president of re-engineering initiatives. **(See story, p. 39.)**

***In This Issue*** **continued from page 1**

**'Career Path' is incentive for access advancement**

✔ *Employees boost skills, paychecks*

A new tri-level 'Career Path' at ScrippsHealth allows self-motivated employees to increase their expertise and move up as much as two salary grades in the process, in addition to receiving normal merit increases. Designed by a committee of the access employees' peers, Career Path was created after Scripps investigated the causes of unsatisfactory levels of bad debt, accounts receivable days, and employee attrition. The first level, which all employees must pass, includes access core competencies, including the fundamentals of insurance and point-of-service collections. Levels 2 and 3 require more advanced knowledge and a demonstration of leadership skills . . . . . 41

**Access manager designs advance beneficiary form to meet HCFA standards**

✔ *New inservice tells staff what to do*

Frustrated by HCFA's failure to provide a template for the advance beneficiary notice (ABN) hospitals are required to provide in the case of uncovered services, Liz Kehrer designed her own. Kehrer, manager of patient access at Centegra Health System, searched HCFA's Web site to find the latest requirements and continues to update the form as new items are added to the 'uncovered' list. She also wrote an inservice explaining in detail how access staff should handle ABNs . . . . . 45

**Should nursing homes pay the hospital bill?**

✔ *AM seeks definitive answer*

What is the proper billing procedure to follow when nursing home residents are admitted to the hospital for services related to an injury? In this month's Access Feedback column, Liz Kehrer, patient access manager with Centegra Health System, seeks the answer to that question. Attempting to follow the Medicare secondary payer guidelines, which require an investigation into other sources of liability in the case of an injury, Kehrer faces opposition from some nursing homes, that say the rule doesn't apply to them . . . . . 48

## COMING IN FUTURE ISSUES

- When physicians don't get preauthorizations
- How the Internet figures in access strategies
- What merging and 'unmerging' mean to you
- HIPPA: The new Y2K for consultants?
- Getting aggressive with upfront collections

Mount Sinai hired a consulting firm to reengineer business processes, and admitting was the first target, she says. The result was the consolidation of several jobs — including scheduling, preadmitting, and admitting — into one position, called "admitting planner," Sullivan says.

"Six years ago," Seligman points out, "there was no admitting system out there that included a true reservation function that would work in an environment of our size." That being the case, Mount Sinai created its own admission planning module and put it on the front end of the existing admission, discharge, and transfer system, he says.

Mount Sinai is considering a move to bedside registration but doesn't see it as a top priority, he notes. "A year or two ago, there wasn't a neat, portable way to move from room to room and admit." Meanwhile, patients seem pleased with the current system, which amounts to nine individual admitting offices located on one of the floors of the care centers they cover. "People like it, and it solves most of the problems. If patients need to go directly to a room, they do."

The proximity of the admitting function to the patient is "nice, particularly for a large hospital

## HCFA to investigate same-day readmissions

Hospitals with high numbers of Medicare same-day readmissions may get some unwanted attention from the Health Care Financing Administration (HCFA).

The Office of the Inspector General has asked HCFA to investigate hospitals with above-average claim rates, according to a report just released by the Department of Health and Human Services. HCFA was instructed to review claims for multiple continuous same-day readmissions and to look at a sample of claims where same-day readmissions were coded with the same diagnosis-related group as the first hospital stay. HCFA may suspend payment for same-day readmissions pending verification of their appropriateness.

*Hospital Access Management* will report further on the pending investigation in the May issue. ■

like this," he adds. "When you have a central admitting office, that bed might as well be in the Philippines. They're telling you it's empty and clean, but maybe it's not."

Now the business associate "has something to do with saying goodbye to the patient who left and may have been the person who called the family to pick up the patient. The business associate is doing the chart preparation, the appointment scheduling, preadmission, admission, and is like a unit clerk," explains Seligman.

Physicians praise the new arrangement, Sullivan notes, relishing the fact that they're dealing with the same two or three people on each admission, rather than any one of 20 or 30 admitting planners.

"The biggest benefit and the lesson learned is that we took a large hospital and made it into [nine] smaller ones," she adds, "bringing leadership and authority down to a more local level. The business associate has a working knowledge of who's coming and going and can be more specific about date, bed, and time."

Although Sullivan says she's still unsure that the new way of doing things is "that much less expensive," she's positive it costs no more than the old way. In an industry where "patient-focused care" and decentralization efforts routinely deteriorate into money pits, that's a dramatic endorsement.

"It's all a matter of how you approach it," adds Seligman. "Many, many institutions use the phrase 'patient-focused care' to mean, 'We cut the skill mix and saved money.' A lot of the bad connotation is that it is a fancy word for fewer nurses. Our project intended to find a savings that wouldn't cut bedside nurses."

With that in mind, he says, Mount Sinai project leaders "talked to every [consulting] company we could find," finally selecting a firm called Patient Focused Care Associates, which has since disbanded. The result was "a very nice partnership," with one overriding theme: "Every redesign step has to have an economic target. We don't go forward with the design otherwise. Savings requirements are built into every step of the process."

That means less management and less support staff, he points out. "I don't want to suggest that everything is perfect. It's a skinnier scheme. There's a lower head count on floors than we used to have. People come to you to complain that on the night shift there is no one supervising the support associates."

Ensuring the quality of registration data is "definitely one of the challenges," Seligman says. The finance department initially double-checked every admitting packet and provided feedback to every care unit. "They still do a lot of checking and [issue] a weekly report about incomplete packets."

The registration process, Seligman explains, typically works like this:

"When the physicians, 95% of whom have a 'home' care center, have a patient to be admitted, they call that center and talk to the business associate, who takes the information, calls the patients [to preadmit], and then [passes the account] to a financial screening person. It's an easy handoff because of the computer system."

In three of the nine care centers, however, financial planning has been added to the duties of the business associates, Seligman notes. Plans are to extend that function to the other care centers as the necessary training is completed, he says. That process has been slow-moving because of the feeling that whoever does the financial piece must spend a month in training, he explains.

Despite the ongoing challenges, he says, the result of Mount Sinai's re-engineering is "a better-functioning hospital at a lower cost." Staff are more accessible to patients, and physicians and business associates feel more a part of the care team, he adds. "Patients feel that difference." ■

## Designing jobs correctly is key to decentralization

*Lack of leadership can foil efforts*

It's a myth that decentralization is more expensive, says **Patricia Garcia Sullivan,** RN, vice president of re-engineering initiatives at Mount Sinai Medical Center in New York City.

The key to decentralizing efficiently, she says, is correctly structuring and packaging the jobs involved. Not giving enough thought to constructing the new jobs may result in a lot of variability in activity, Sullivan suggests.

Because the job doesn't have enough flexibility, employees find themselves overwhelmed at times and with nothing to do on other occasions, she adds. "You need a critical mass of things for these people to do to make it viable."

Health care organizations that fail to decentralize their services might look at these other potential reasons, Sullivan says:

• The organization was tremendously efficient to begin with.

• The organization didn't fully conceptualize the process and take advantage of technology and process redesign.

• There was a lack of real leadership.

"Many times, what I've seen in re-engineering initiatives that fail is that [the organization] falls back into silos," says Sullivan. "There must be some sponsor at the executive level who doesn't have a vested interest in the outcome."

At Mount Sinai, the majority of managers and directors of areas affected by re-engineering reported to the chief operating officer, she points out. "Other organizations may put the oversight at too low a level, and that doesn't work. You can't give [the project] to the vice president of nursing to run."

## *'Decision tree' aids process*

When Mount Sinai started its full-scale re-engineering effort in 1993, the hospital created three or four clinical teams to lead the project, later pulling off some members to form a business team, Sullivan says. That team oversaw admitting and other business functions.

The idea of decentralization was put through a "decision tree" to determine the best place to locate services, she adds. "This forces you to describe a service in detail, to answer questions about processes and subprocesses." Looking at admitting, for example, the team asked:

• **What are the capital and equipment needs?** They are relatively low and include such items as admitting software and equipment to make patient ID plates, telephones, etc.

• **How long does it take someone to learn the procedures?** The team determined it would take someone about four to six weeks to become competent, but not an expert, in admitting skills.

• **How many admissions does one have to do on an ongoing basis to stay competent?** The team decided someone could stay up to speed on admitting skills by doing at least one admission per day.

• **Are certain functions concentrated in particular patient groups?** This is not true of admitting because it is spread across the hospital. With a function such as phlebotomy, however, there would be more concentration in some patient groups than others.

After answering "yes" to the question of whether the hospital could afford to replicate the admitting service based on equipment needs, the team moved down to some other questions:

• **Does the ability to do this function in more local units improve performance indicators?** "With admitting, that's a definite 'yes,'" Sullivan notes. "If [an account] needs follow-up, [the business associate] is right there."

• **Is volume high enough to ensure at least one person in the care center is competent?** "If the answer to that is 'yes,' keep going," she says. "It could be that you have a small care center with 10 admissions a week, or two a day. That could keep one person competent but maybe not two. Maybe you want a specialist in admitting that works for one unit."

In a big care center, Sullivan adds, there might be five or six business associates, with at least 25 admissions needed to keep those employees competent. "There may be a specialist who only does admitting, or multiskilled people who do admitting and other things, but each person must do at least one admission a day," she explains.

After going through the decision process, the team decided that admitting could be "multiskilled" at most care centers, Sullivan notes.

Another question to be addressed is whether a task is deferrable, she says, meaning that it can be delayed as long as it is done within one day. "If you multiskill a lot of tasks, you have to be careful that they're not all nondeferrable. You don't want people batch-entering all the admissions at the end of the day, so that's a nondeferrable activity."

Although Mount Sinai went with a multiskilled business associate, what has developed, Sullivan says, is an employee who is "less truly multiskilled and more semispecialist."

"It definitely evolves," she adds. "There is a natural tendency to pull back more centrally, but what we've succeeded in is keeping [admitting] care center-based and care center-specific. You end up with personnel with different strengths and weaknesses."

In another change, while the hospital first went with one job description for business associates, after two years the position was split into "business associate A" and "business associate B," she says. "The lower-level position reflects those who don't do admitting, which some employees don't have the desire or capability to do."

She points out, however, that the hospital traded some flexibility for the cost efficiency it

gained by not having to pay all associates a higher wage. With fewer of the associates able to do admitting, scheduling becomes harder, she says.

"In general, the admitting process is one of the big satisfiers for patients," Sullivan adds. "It's about relationships and being able to get more concrete information."

And there's one more measure of success: The re-engineered Mount Sinai recently received the highest rating in its history — 97 — from the Oakbrook Terrace, IL-based Joint Commission on Accreditation of Healthcare Organizations.

*[Editor's note: Patricia Garcia Sullivan may be reached at (212) 241-6581 or by e-mail at psullivan@smtplink.mssm.edu.]* ■

# 'Career Path' is incentive for access advancement

*Employees boost skills, paychecks*

The comprehensive training that access representatives receive at ScrippsHealth in San Diego includes a new tri-level "Career Path" program that allows self-motivated employees to increase their expertise and paychecks.

For each advanced competency level they reach, access reps can boost their salaries by 5%, in addition to being eligible for an annual merit increase of up to 5%, says **Mollie Drake,** MBA, access director. Completion of the first competency level is required of all access employees.

The genesis for Career Path came after Scripps formed a committee in February 1999 to investigate the causes of the system's unsatisfactory levels of bad debt, accounts receivable days, and employee attrition, Drake says. "We went out to all of the six Scripps facilities and the central business office and asked a member of the line [access] staff to join the committee to take a look at all this and what we could do to correct it."

With feedback from the committee and the results of a staff survey, "we realized a lot of problems had to do with motivation and training," she notes. "Training was inadequate, employees were not motivated, and access representative was a dead-end position. There are 400 access representatives. The next level is access coordinator, and there are only 25 of those in the system."

Based on that information, the committee designed a three-tiered Career Path, "so it was created by peers," Drake points out. **(See training matrix chart, pp. 42-43.)**

Level 1, called the "core competencies," is the only one required of all access representatives and includes mastery of information in these areas:

- fundamentals of all insurance payer types, including Medicaid, health maintenance organizations, and managed care organizations;
- point-of-service collections;
- coordination of benefits;
- overview of hospital billing;
- professional skills such as customer service and communication;
- patient confidentiality.

The information is covered in 21 classes taken either in a classroom setting or through a self-directed workbook, and Scripps is working to set up a computer-based teaching program, Drake says. The alternative methods allow the program "to reach out even to the person in emergency department on the odd Friday graveyard shift." New hires are exposed to the information in a nine-day "boot camp," she adds, and then have one chance to pass the level 1 core competency test. **(For additional information on ScrippsHealth training and collections practices, see *Hospital Access Management*, March 2000, pp. 25-30.)**

At that level, existing employees may choose to take classes covering only the areas they are weakest in before taking the level 1 test, Drake notes; for levels 2 and 3 they are required to complete all the courses.

Existing staff were given 90 days' notice, on Dec. 15, 1999, that they would be required to pass the core competency test, she says. Training classes began then and were offered through March 15, at which time employees got their first chance to take the test, Drake explains.

"They get three chances to take the test," she says. "If they fail it the first time, we will sit down with them and show them their weak areas. They can get additional training and try again in 30 days. If they still fail, we review again." If the employee fails the test a third time, the reasoning is that he or she should not be in that position, and the failure could lead to termination or to a move to a position such as receptionist or cashier, Drake adds.

*(Continued on page 44)*

Access Representatives
Administrative Partners
Training Matrix

| Training | Core Competency | Access Rep II | Access Rep III |
|---|---|---|---|
| **Professional Skills** | | | |
| Business Correspondence | | X | X |
| Collection Techniques | | X | |
| Conducting an Inservice | | X | |
| Conflict Resolution | | X | X |
| Cost/Benefit Analysis | | | X |
| Customer Service | X | X | X |
| Dealing with Difficult People | | X | |
| Effective Communication | X | X | X |
| Effective Presentations | | | X |
| Ethics in Business | | | X |
| Motivational Skills | | | X |
| Patient Confidentiality | X | X | X |
| Project Management | | | X |
| Team Building | | X | X |
| Technical Writing | | | X |
| Telephone Skills | X | | |
| Time Management Skills | X | | |
| **Technical Knowledge** | | | |
| Active Duty Coverage | X | | |
| Assigning Leins | | X | |
| Capitation | X | | |
| Case Management | | | X |
| COB/TPL | X | | |
| Commercial Insurance | X | | |
| Disproportionate Share | | X | |
| Follow Up Queues | | X | |
| Health Information Overview | | X | |
| HMOs | X | | |
| Hospital Billing Overview | X | | |
| Medi-cal Overview | X | | |
| Medi-cal/CMS Eligibility | | | X |
| Medical Terminology | X | X | X |
| Medicare Compliance | | X | X |
| Medicare Cost Report | | X | |
| **Technical Knowledge** | | | |

Access Representatives
Administrative Partners
Training Matrix

| Training | Core Competency | Access Rep II | Access Rep III |
|---|---|---|---|
| Medicare Overview | X | | |
| Patient Accounting | X | | |
| Patient Registration | X | | |
| Payer Contracts | | X | |
| PPOs | X | | |
| Report Writing | | X | X |
| Revenue Management | | | X |
| Risk Pools | | X | |
| Scheduling System | | X | |
| Secondary Systems | | X | |
| Self Pay Negotiations | | X | |
| Senior HMOs | X | | |
| System Troubleshooting | | X | |
| Tri-Care/CHAMPUS | X | | |
| Unbilled Accounts | | X | |
| Understanding the Chargemaster | | X | |
| Utilization Review | | X | |
| Worker's Compensation | X | | |
| **Quality Improvement Tools** | | | |
| CQI Mastery | | | X |
| ISO 9002 | X | X | X |
| Microsoft Excel | | | X |
| Microsoft Power Point | | | X |
| Microsoft Project | | | X |
| Microsoft Word | | | X |
| Process Mapping | | | X |
| Statistical Process Control | | | X |

*Source:* Information on pp. 42-43 is courtesy of ScrippsHealth, San Diego.

As of 1/27/00

(Continued from page 41)

To attain access level 2, which is optional, employees must complete a more advanced series of 27 classes, which address hospital financing and patient accounting, she says. The following topics are covered:

- how a payer contract is negotiated;
- how to read a payer contract;
- more on Medicare compliance;
- how a risk pool works;
- trouble-shooting and other in-depth computer skills;
- negotiating self-pay contracts.

After successfully completing those courses, the employee seeking advancement completes an application form demonstrating how he or she has applied the course work to the job, Drake says. "For example, [the employee] may have taken on more difficult accounts, provided an inservice to co-workers, or resolved complex problems that before might have escalated. We don't want them to go through the training and then walk away and not utilize it."

The application goes to the oversight committee, made up of the employee's peers, which decides if the applicant has made an adequate demonstration of his or her skills, Drake says. "This takes out the element of 'the manager will never think I'm doing enough.'"

Employees who complete and pass the peer review are promoted one salary grade and receive the promotional pay increase, Drake adds.

The 26 classes required for access level 3 focus on individual professional development and cover these areas, among others:

- project management;
- cost-benefit analysis;
- mastery of Microsoft Office Suite products;
- continuous quality improvement mastery.

Applicants are asked to submit a proposal for a performance improvement project they will lead, Drake says. One such project, for example, might be running a series of reports and coming up with an average cost by length of stay for various procedures. "This could be used as a tool for others."

The proposal must be approved by an access leadership team to make sure no one else is working on the same idea and that it is within the scope of the employee's activities, Drake explains. Once the leadership team approves the idea, it assigns the employee a mentor who has expertise in that area. "For example, if the project is to make changes in the chargemaster, the employee would be assigned someone from that department."

Employees seeking level 3 certification may submit a proposal as soon as they complete level 2, so as they take the level 3 courses, they can work on their project simultaneously, Drake says. "To achieve level 3, the employee comes back to the leadership team and presents the results of the project. The team will determine if [the project] has been adequate to promote the employee."

### Peers teach the courses

Although Scripps employs a professional educator who provides information on how to educate the adult learner, trainers for Career Path courses come from the employees' peer group, she points out. "They were senior staff members before we started Career Path who usually were tapped for training anyway. Now they are full-time trainers and are called 'access training specialists.'

"If [the trainers] don't understand something [in the course material], they have to go out and find a system expert," Drake says.

The training and development department — not the access managers — oversee the Career Path program, she notes, which prevents any conflict of interest. "The [access] managers don't decide who gets to strive for a level. They can't look at a budget and say, 'I can't promote that person. I'm over budget on payroll right now."

For the most part, access staff have reacted positively to the new program, Drake says. "They're very appreciative of the chance to advance and excited about the formal training because the training has been so hit-and-miss in the past. Many who are longtime employees were already hitting the [salary] ceiling of level 1, so they had been without the opportunity to increase their pay for a while. This opens that up for them, because the ceiling is raised as they go up the ladder."

Some employees are apprehensive about the required core competency test, Drake adds, "but as we continue to provide workbooks and classes, they're getting a comfort level."

Staff initially were concerned there might be "trick" questions or the program was a way for management to decrease staff, she says. "We've assured them that, since we have no vacancies, the last thing we want to do is get rid of people. We just need an objective way to know if they have a basic understanding of the business." ■

# AM designs ABN form to meet HCFA standards

*New inservice tells staff what to do*

With the Health Care Financing Administration (HCFA) continuing to tighten the rules regarding Medicare coverage, access managers are scrambling to help protect their hospitals' bottom lines. HCFA announced last year that hospitals — if they want to bill Medicare patients for uncovered services — must have patients sign an advance beneficiary notice (ABN) explaining that a service may not be covered and why.

With no ABN template available from HCFA, **Liz Kehrer,** CHAM, manager of patient access at Centegra Health System in McHenry, IL, decided to design her own form, using HCFA guidelines. **(See form, p. 46.)** She went to the HCFA Web page (www.hcfa.gov) to see exactly what the form needed to contain. She also developed an ABN staff inservice. **(See p. 47.)** (She notes that "Medicaid" is included on Centegra's form because the Illinois Medicaid program follows Medicare rules. That may not be true for other states.)

Previously, the Medicare notice of noncoverage given to patients listed the categories for potential denial, Kehrer points out. The new ABN, however, must be specific about the reason for denial. When the form states, for example, that a routine screening exam is not covered, it now must indicate at the bottom the specific test that — in that patient's case — may not be covered. **(See list, below.)**

The most frustrating aspect of the process, Kehrer says, is that the rules keep changing, and most hospitals learn of the latest noncovered service only when they receive a denial of payment. "I have added more items [to the form] as a result of the denials we've received." Just recently, she says, her hospital was denied payment for 24-hour ambulatory blood pressure monitoring ordered for a patient with hypertension. HCFA put that procedure in the same category as a routine blood pressure check, she adds. "Despite the time involved, HCFA considered it a screening."

Like many of her access colleagues, Kehrer is "only trying to do the right thing, but trying to get the information to do the right thing is like pulling teeth." While the government is quick to threaten with fraud and abuse citations and fines, it offers little help to hospitals seeking advance notice of services that are not covered, she adds. ■

## List of Laboratory Tests/LMRPs*

Here's the information from the bottom section of the advance beneficiary notice (ABN) form that **Liz Kehrer,** CHAM, manager of patient access at McHenry, IL-based Centegra Health System, designed for her hospital.

* LMRP = Health Care Financing Administration's local medical review policy.

**Medicare limited-coverage tests.** We believe in your case Medicare is likely to deny payment for:

☐ Allergen-specific IgE sensitivity
☐ Bacterial culture
☐ Blood counts (CBC)
☐ Cytogenetic studies
☐ Digoxin
☐ Ferritin
☐ Gamma glutamyltransferase
☐ Glucose
☐ Glycated hemoglobin
☐ Glycated protein
☐ Immunoassay for tumor antigen
☐ Unlisted immunology:
— Alpha-fetoprotein
— CEA
— Gonadotropin
— CA125 Ca27-29
☐ Iron studies:
— Iron
— IBC
— Transferrin
☐ Lipid profile
— Cholesterol
— Triglyceride
— HDL, LDL, VLDL
☐ Magnesium
☐ Pap Smear:
— Screening
— Diagnostic
☐ PTT
☐ Platelet counts
☐ Prostate-specific AG (PSA)
☐ Prostatic acid phosphatase
☐ Protime
☐ Reticulocyte counts
☐ Rheumatoid factor test
☐ Syphilis test
☐ Thyroid function studies
☐ Troponin (and/or CK)
☐ Urine culture
☐ OTHER (specify):_____

CENTEGRA Health System

# Medicare/ Medicaid *Advance Beneficiary Notice (ABN)*

**Patient Name:** _____ **Date of Birth:** _____ **Service Date :** _____

**Ordering Physician:** _____ **Account Number:** _____

**MEDICARE A** (includes MEDICARE PART B) **/ MEDICAID**

*(Services exempt from Medicare/ Medicaid coverage)*

Medicare A (includes Medicare Part B)/ Medicaid will only pay for services that are determined to be "reasonable and necessary" under Section 1862(a)(I)(A) of the Social Security Act. If a particular service is not "reasonable and necessary" under governmental standards, although it would otherwise be covered, Medicare/ Medicaid denies payment for that service. Medicare/Medicaid program will allow the patient to be billed for denied limited coverage services only if an ADVANCE BENEFICIARY NOTICE (***ABN***) is completed, signed and dated by the patient, and forwarded to the service provider **PRIOR TO THE TESTING**. It is the physician's responsibility to ensure that the beneficiary receives and signs an ABN to accept financial responsibility if Medicare/ Medicaid does not pay for these services. The service indicated below is likely to be denied payment.

**Exam/Test(s)/ Procedure** *(list exam/ test/ procedure)* : _____

_____

Routine/Annual physicals, any screening exam/test that is not performed to treat or diagnose a specific illness or injury; also any exam/test called for by a "third party," such as an insurance company

Mammography ***screening*** if not performed within the frequency limits listed below:
Under age 40 - no coverage Ages 40 & over - one every 12th month **Last Mammo screening date:** _____

Immunizations unless they are to treat an injury or protect you from a disease you've been exposed to

Cosmetic (Plastic) Surgery unless required to repair an accidental injury or to improve the working of a malformed body part

Dental Services includes cleaning, fillings, tooth removal, or replacement, unless a dental procedure done in the hospital while you are hospitalized for some other medical conditions

Nutritional Consults for outpatient visits (*except for Diabetic Education; requires a physician order*)

Ambulatory Blood Pressure Monitoring (*includes 24 hour Ambulatory Blood Pressure Monitoring*)

Audiology Services (*Evaluation, Hearing Aids, Batteries*)

Custodial Care such as bathing, dressing, feeding or other care that does not require an acute care facility

Laboratory Screening (*Blood Glucose & Cholesterol Screening*). **Please see other side for listing** of Local Medical Review Policy (LMRP) tests

**DIAGNOSIS:** _____

***Potential reason for Medicare/ Medicaid denial*** *- Check one or more applicable reasons:*

Does not pay for routine exams and tests for screening purposes

Does not pay for this service for the diagnosis provided

We cannot establish medical necessity for this test because the ordering physician provided no diagnostic information

Pays for tests for a limited number of times within a specified time period and the patient is over the limit or there is no way for us to determine whether other institutions have previously billed Medicare for tests to this patient

Does not pay for tests that are for "investigative" or research use only

Does not pay for tests that have not been approved by the Food and Drug Administration

**Beneficiary Agreement**

I have been notified that, in my case, Medicare A/ Medicare B/ Medicaid is likely to deny payment for the services identified above, for the reasons stated. If Medicare A/ Medicare B/ Medicaid denies payment, I agree to be personally and fully responsible for payment (I will have to pay out of pocket or by any other insurance coverage I may have). **Approximate test(s) cost $ _____.**

____ *I agree to receive the service ordered* ____ *I decline the service ordered*

___ *I received a copy of this form*

_____ Signature of Beneficiary

_____ Witness

_____ Date

03911063X rev 02/00 White: Billing File Yellow: Physician Pink: Patient

# Inservice informs staff of Medicare/Medicaid ABNs

Here is the text of a staff inservice fact sheet on advance beneficiary notices developed by **Liz Kehrer,** CHAM, manager of patient access at Centegra Health System in McHenry, IL:

**✔ ABN instructions**

Medicare / Medicaid program restrictions do not allow for coverage of diagnostic testing in the absence of signs and symptoms / illness. ***The tests must be medically necessary.*** Providers must notify the patient in writing that Medicare / Medicaid will likely refuse to pay for a specific test / treatment. This notification, called an ***advance beneficiary notice (ABN)***, must be given ***before*** the test / treatment is given. The reason(s) the service may not be covered must be stated. The health care provider ***cannot*** issue a general notice stating that Medicare / Medicaid denial of payment is possible or that the provider is not sure if Medicare / Medicaid will cover the prescribed service or treatment.

The information on the ABN form should include the service(s) ordered, the date of the service, the diagnosis and the specific reason why Medicare may decline payment. After the ABN has been explained to the patient, the patient decides whether to receive or decline the service and sign the ABN. The patient will then be financially responsible for paying the service(s) fee if Medicare / Medicaid declines payment.

The provider cannot collect any money from the patient for the service if a completed ABN was not signed by the patient ***before*** the service(s).

***Present an ABN only if you doubt payment.*** Do not routinely ask ***all*** Medicare / Medicaid patients to sign an ABN. Use the ABN only when you believe Medicare / Medicaid will deny payment for an ordered tests for one or more of the reasons listed in the ABN. Complete the ABN before presenting it to the patient. You must fill in the information before you present the ABN to the patient for signing. You ***cannot*** have a patient sign a blank form and then fill in the information later. Fill in the patient's name, date of birth, service date and the ordering physician's name at the top of the ABN. Write the name of the ordered test / treatment. Check-mark which category of service you believe the ordered service falls under. Fill in the diagnosis and check mark the applicable potential reason(s) for Medicare / Medicaid denial. Obtain and fill in the approximate cost.

You are now ready to ask the patient if he or she agrees or declines the service(s) and ask the patient / guardian to sign the form. **If the patient agrees** to have the service and signs the form, the patient accepts responsibility for payment in the event Medicare / Medicaid does not pay for the test(s) performed. **If the patient declines** or does not want the test(s) performed, since he / she is not willing to accept personal responsibility for payment in the event Medicare / Medicaid does not pay for the ordered test(s), the ABN is still signed to document the discussion with the patient and the patient's decision.

**If the patient refuses to sign the ABN but still wants the test to be performed**, you should ask a fellow Associate to witness that the patient has been notified of the specific information provided in the ABN; namely, that Medicare / Medicaid is likely to deny payment for the specific test(s)

**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.

## Subscriber Information

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

**Subscription rates:** U.S.A., 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.)



Editor: **Lila Margaret Moore,** (520) 299-8730.
Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan.hasty@medec.com).
Managing Editor: **Kevin New**, (404) 262-5467, (kevin.new@medec.com).
Production Editor: **Terri McIntosh**.



**Editorial Questions**

For questions or comments, call **Kevin New** at (404) 262-5467.

ordered, the reason(s) for doubting payment, that the patient could be personally responsible for payment in that instance, and that the patient had the right to refuse the test(s) but chose to have the test performed. Tell the witness to sign and date the bottom of the ABN form. ■

## ACCESS FEEDBACK

# Should nursing homes pay the hospital bill?

What is the proper billing procedure to follow when nursing home residents are admitted to the hospital for services related to an injury? That's the question **Liz Kehrer,** CHAM, manager of patient access at Centegra Health System, McHenry, IL, would like answered. In line with Medicare Secondary Payer (MSP) guidelines, she has told her staff to investigate whether the nursing home's liability insurance carrier should be the primary payer in such cases. "Before we can bill Medicare, we have to exhaust all other sources of liability," she says.

The problem she faces is that administrators at a couple of the nursing homes she deals with say the MSP rule does not apply to them because the nursing homes are the primary residences of the people who live there year-round. She has been unable to find any clarifying documentation. "Is this true or not?" she asks. "I went to a seminar last year where we were told that many hospitals have received fines because of all the nursing home transfers. I feel that I am caught in the middle. Does anyone have this clarified in writing? Is a nursing home in fact considered a person's primary residence? Does that meet the Health Care Financing Administration [HCFA] definition, in which case a liability investigation does not apply?"

Either way, she needs something in writing. "If a HCFA auditor comes in and says, 'There should have been an investigation,' or 'This should have been billed to the liability carrier,'" she needs something concrete to back up her decision. She also needs something to show the nursing home officials to obtain their cooperation.

*[If you have feedback on this issue, call editor Lila Moore at (520) 299-8730 or e-mail her at lilamoore@mindspring.com. Liz Kehrer may be reached at (815) 344-5000. E-mail: lkehrer@centegra.com.]* ■