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JANUARY 2007
VOL. 26, NO. 1 • (pages 1-12)

Technology increasingly important in effort to ensure correct patient ID

Health system uses on-line tools, training to prevent error, fraud

News reports in recent months tell of computers with data on Medicare and Medicaid patients being stolen from a health system's regional office and a former hospital worker charged with fraud and identity theft for accessing and selling patient files.

Some patients, meanwhile, attempt to pay for their care with stolen insurance cards or give false Social Security numbers so hospitals won't be able to bill them.

Medical identity theft occurs when someone uses a person's name — and perhaps other pieces of identifying information, such as an insurance card — without the person's consent to obtain medical services or goods, or to make false claims for medical services, according to the World Privacy Forum.

It often results in erroneous data being put into existing medical records and can involve the creation of fictitious medical records in the victim's name, notes **Patti Consolver,** CHAA, CHAM, corporate director of patient access at Arlington-based Texas Health Resources (THR).

With increasing attention on preventing these kinds of crimes, says Consolver, on-line tools and other technology to ensure proper patient identification that were once "nice to have" are now in the "must-have" category.

"Technology like biometrics **[see related story, p. 4]** leaves little room for error, lifts the burden from the registration personnel and, more importantly, offers patients a safe and secure process for their personal medical information," she adds.

THR, a 13-hospital system with more than 2,400 licensed beds, uses on-line processes to screen Social Security numbers and credit information for fraud alerts and to verify the accuracy of a patient's address, Consolver says.

With the Social Security software, for example, staff may receive an alert saying that the number given belongs to a deceased person or has never been issued.

When presented with that result, patients in some cases will admit the deception, Consolver adds. "You may find that an illegal immigrant has purchased a Social Security card. Sometimes they'll come right out and tell you that."

In other cases, even when staff know they've been given bad information, she says, "patients are adamant that it is the right number," knowing that they won't be refused care.

Although technology provides a big advantage in ensuring accurate patient identification, it is far from infallible, Consolver notes. One system, for example, goes out and verifies that a mailing address is actually a valid address, she says, but it doesn't say that the patient lives there.

A program such as Equifax that looks at a person's credit history will show the last three or four known addresses for that person, Consolver says, but they might be out of date, depending on the last time a credit check was done.

"At least these are tools that allow you to go out and try something else," she says. "It's just something that we need to make sure is a priority."

One of THR's on-line training modules addresses the issues associated with medical identify theft, Consolver notes. "Before, [registrars] would make a copy of an insurance card or a driver's license, file it, and not think twice." Now, she adds, they are instructed to "do a double check, make sure it matches, that the right one is in front of you, and take note of anything that seems suspicious."

THR access employees are told to involve the management team any time there is a concern with an account, she adds. Scripting has been developed to help staff communicate courteously and effectively with patients when questions come up regarding their information.

"If patients see [the registrar] looking at their credit or address information, they want to know where it's coming from," Consolver says. "You need to be careful how you explain that. You don't want to cause a bigger customer service dissatisfier."

Registrars certainly don't want to come across as though they are accusing the patient of lying, she adds.

Consolver suggests saying something like, "Our computer system is showing this. Can I double check that this is the right one?"

Protecting the patient's information is just as important as determining when what is presented is not accurate, she maintains. "Historically, patient access staff have made a copy of the driver's license and the insurance card, but copying this information can be as detrimental as copying a credit card."

If scanning is not an option, Consolver suggests, security measures need to be in place to ensure that such data are treated as protected health information.

Medical identity theft, she points out, frequently results in erroneous entries being put into existing medical records and can involve the creation of fictitious medical records in the victim's name.

This crime can be difficult to uncover, and may

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals 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@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $80 each. (GST registration number R128870672.)

Editorial Questions

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go unnoticed for years, Consolver adds, and with HIPAA constraints it can be difficult to view all pieces of a medical record to determine inconsistencies or fraudulent entries.

Those whose medical information is stolen, meanwhile, do not have clear pathways for recourse and recovery, she notes. "The Fair Credit Reporting Act allows for greater recourse for victims of financial identify theft than the HIPAA health privacy rule provides for victims of medical identity theft."

SS number no longer patient identifier

THR has used Social Security numbers as patient identifiers for more than 20 years, but discontinued the practice earlier this year for all new patients, notes **Tauna Shelton,** MHSM, MS, CHC, regional director, compliance and privacy.

"The issue came up and we had been trying to address it for some time, but we needed software and changes made to the computer system," Shelton says.

Concern on the part of customers prompted the action, she adds. "We want to make them comfortable, and it's such a compliance issue."

Her office, in conjunction with the security department, also has developed a toolkit to assist those who suspect that identity theft has taken place, Shelton says. "There is a whole packet that an individual can use to report theft or suspicion of theft [of patient information]."

In addition to a Federal Trade Commission booklet and other explanatory information, there is a questionnaire to help people determine their level of risk, she says.

Reports of possible instances of identity theft may come from a variety of sources, Shelton notes, including anonymous phone calls to a hotline by, for example, an employee who observes another employee doing something inappropriate. In other cases, she adds, a manager might question why an employee has certain information.

Another warning sign would be if a patient who has used a credit card to pay the hospital bill suddenly notices charges on the card that he or she has not made, Shelton says. "They notify somebody here and we begin to investigate, to see if an employee is holding on to a Social Security number or any kind of protected health information. So far nothing like that has happened here.

"What we have done when we have had potential cases is monitor that individual's accounts for credit agencies to see if there is any unknown activity," she adds. "We would contact the credit agency because the patient felt there was a problem or we came across something [suspicious] and wanted to make certain the individual was protected."

If there is a potential case of identity theft, Shelton says, a notification form is sent to the patient, including any information that might help them. "We give them the names of credit agencies, with phone numbers, and inform the patient that we will follow up with them."

THR employees are required to complete computer-based business ethics and compliance programs, which combined with HIPAA privacy and security material take about six hours to complete, she notes. "So we aggressively address this issue from a training point of view."

Document imaging promotes data security

The billing offices and health care facilities of Texas Health Resources are using a document imaging system to scan, view, fax, and store visual patient identifiers at their work stations, says **Linda Powell,** CHAM, director of patient access services at Harris Methodist Fort Worth Hospital.

"The patient identifiers are imaged and stored electronically, similar to the way you would file documents in the folder of a filing cabinet," Powell adds. The goal, she says, is to reduce billing errors and medical record duplication and provide patient safety by retaining accurate patient identification for future use.

"We're a trauma center, and a lot of times we don't get the most common forms of identification upon arrival of the patient," she notes. "Often we may get only a name from the local ambulance service, which is not enough to positively identify an individual as a previous patient when we search the Master Patient Index for a previous account.

"The most commonly acceptable patient identifier is the name and the date of birth, and sometimes the Social Security number," Powell says. When this information is not available, secondary patient identifiers — such as where a patient works, the name of their insurance company, or the fact that the patient was previously admitted at the facility — may come into play, she adds, "and more often than not, they cause a problem."

Document imaging, in place at Texas Health Resources since early 2005, "provides a way to positively identify patients using stored images on file," Powell notes. "You'd be surprised how many people leave home with just their car keys and a coat."

Powell says she knows from personal experience the problems that can ensue when institutions rely on secondary patient identifiers. She experienced them firsthand when her identity was confused with that of another Linda Powell, who also has the same middle initial, maiden name initial, and several other secondary identifiers.

With document imaging, such confusion doesn't occur, she points out. "You go into a previous account, acquire patient identifiers imaged in the system, and know that the person standing in front of you is who they say they are. You can positively identify the patient readily, quickly, repetitively when positive identification is imaged and stored

Deliberate misidentification growing problem in EDs

Director looks at strict countermeasures

When access employees at Lake Pointe Medical Center in Rowlett, TX, register patients, a software program uses name and date of birth to simultaneously check the Social Security number and make sure it is valid, says **Clyde Goins,** patient access director.

If the registrar receives an "alert" saying that the number is not valid, Goins adds, staff double check the number with the patient, explaining to the person that it appears that someone else is using their information. The patient is then told that the hospital will have to report the incident to the police, he says.

"A lot of times at that point the patient comes forward with another number and says, 'Oh, it's actually this,'" Goins notes. "What I personally feel is going on is that some patients, especially in the emergency department, are becoming aware of the fact that we're going to take them [either way], and they intentionally provide bad information."

The hospital has a billing system that automatically sends back patient accounts with incorrect information, such as wrong telephone numbers, he adds, and most come from self-pay patients.

"I'd like to know, to do a study of how much this is going on in the ED," Goins says. "I really believe it's a big thing."

While Lake Pointe Medical Center has only a small uninsured population, with most patients self-pay because they choose to be, he notes, the problem is likely to be more widespread at larger, urban facilities.

The program that checks Social Security numbers has been in place a little more than a year at Lake Pointe, which is a Tenet hospital, but has been phased in over the past five years or so throughout the Tenet system, Goins says. "We were one of the last to get it."

Five years ago, he notes, hospitals "weren't paying that much attention" to double checking Social Security numbers and other strategies to ensure proper identification.

Lake Pointe now has a policy under which staff call local authorities if they know that a person has intentionally given a false Social Security number, Goins says. "We've already made contact with the police department and they've agreed to come out [in such situations]. They probably won't make an arrest, but they will talk to the person."

The hospital hasn't yet gotten to that point, but one of its sister facilities has called the police several times in such situations, he adds.

Whether or not police become involved when a patient is suspected of intentionally giving false identification, having staff take a proactive approach in such situations is likely to be a deterrent, Goins points out.

"The thing that's probably most important," he adds, "is that they won't come back here."

At his next meeting with the ED director and physicians, Goins says, he planned to propose that a policy be instituted whereby some medications are withheld from non-emergent patients who refuse to provide accurate identification.

"Of course we have to stabilize the patient and follow the EMTALA requirements," he adds. "But if the patient doesn't require emergency care, or if we provide care and have to give meds — not antibiotics, but, say, pain meds — we would say that in order for us to provide them, we need a form of identification."

(Editor's note: Clyde Goins can be reached at clyde.goins@tenethealth.com.) ■

in the patient account."

During the registration process, Powell explains, patients are asked to produce:

• Positive identification in the form of any photo ID, preferably with evidence of mailing address.

• Current health insurance card for services being reimbursed by a third-party carrier.

In addition to providing a way to instantly store and retrieve visual-imaged patient-identifying documents, Powell notes, the process makes existing paper documents available in a secure manner across the network.

"People sometimes just show up at the customer service area," she adds, "and say, 'I need to check on my bill. Can you help me?'"

If the person isn't carrying identification, Powell says, that customer service employee can now look in the file to confirm identity, rather than telling the individual he or she will need to answer correctly a series of questions pertaining to the identity of the patient listed on the account or come back later with positive identification.

Powell advises providers interested in instituting document imaging to select quality equipment and to make sure they get the type that fits their specific needs.

"You can image documents in bulk, so you don't disturb the flow of registration by stopping to scan at an entrance," she says. "You could keep a big basket there and do it by batch when staff are not busy."

Hospitals with fast-track ED registration or a fast-track pre-registration location, for example, might choose such a method, Powell adds.

On the other hand, it might not be cost-effective for a hospital with a completely decentralized registration operation to purchase a large, super deluxe scanner that sits in one area, she notes.

"We have desktop scanners on every registration desk at Harris Methodist Fort Worth Hospital, and we also do bedside registration, so we have scanners on our computers on wheels," Powell says. "We have eight buildings and 17 decentralized points of entry where registration functions are performed.

"Analyze your business and determine how best to get the job done," she suggests. "We bought a big scanner just in case, but we really don't use it often." Quality is important, Powell adds, because some types of equipment scan documents faster than others, which obviously has an impact on registration flow.

When putting a program in place, she continues, "Look at what you're really trying to accomplish — patient safety by establishing positive patient identification, reduction in duplicate medical records and reduction in billing errors — and put a process and policy in place where you start to collect valid patient ID upon admission."

Reeducating the public is sometimes a difficult task, Powell cautions. "If customers aren't used to bringing identification, it might take awhile before it becomes common practice to do so."

(Editor's note: Patti Consolver can be reached at PattiConsolver@texashealth.org. Tauna Shelton can be reached at TaunaShelton@texashealth.org. Linda Powell may be reached at LindaPowell@texashealth.org.) ■

Texas biometrics project targeted Medicaid program

Technology to reduce fraud tested

A biometrics pilot project at Harris Methodist Fort Worth Hospital was virtually seamless in terms of staff training and patient participation and showed great potential for reducing fraud and enhancing customer service, says **Jeff Ferrell,** CHAA, CHAM, director of the Texas Health Resources (THR) patient access intake center in Arlington.

The Harris Methodist project was part of an initiative by the Texas Health and Human Services Commission to test technology to reduce fraud and abuse, adds Ferrell, who was manager of patient access services at Harris Methodist at the time.

Harris Methodist Fort Worth, a 600-bed tertiary care referral hospital, is located in Tarrant County, one of six Texas counties that participated in the Medicaid Integrity Pilot, he says. The program was developed, Ferrell notes, to prevent two types of fraud within the health care system: medicaid identity fraud and phantom billing.

"There were several vendors that got a contract [to participate]," he says. "They wanted to decide which had the best practice." The participating hospitals were not told which vendor's technology they were using, Ferrell notes.

Under the terms of Harris Methodist's part of the project, he explains, 100,000 Medicaid patients in Tarrant County were issued a Texas Health and

Human Services Commission Medicaid Integrity Card. In addition to the words, "State of Texas," the state seal, and the participant's name, Ferrell notes, the card contained a "smart chip."

"It was up to the hospital or the first [provider] to see the patient to capture the person's fingerprint on the card the first time," he says. A number of physicians throughout the state also participated in the project, Ferrell adds.

Hospitals were given two kinds of equipment to use as they deemed appropriate, he says. One was a keyboard with a card reader and an accompanying identification pad that looked like "a little hockey puck," with a piece of glass on top where patients put their fingers, Ferrell says.

The other option, for those who didn't want to install new keyboards, was a stand-alone card reader with a small "wallet" on top into which the card could be slipped and above that a place to put the finger in, he adds.

Harris Methodist used both devices — the keyboard in the main registration areas and the stand-alone reader for the emergency department, Ferrell notes. "For the ED, it was easier to have the little 'wallets' on a kind of cord connected to the computer on wheels that was used for bedside registration."

At Harris Methodist Fort Worth, the biometric application and readers were deployed to 22 separate access areas, he says.

During the six-month pilot, Medicaid recipients being admitted to the hospital were asked if they had their "integrity cards." If they did — not all Medicaid recipients were issued the cards — the registrar took the card and inserted it in the slot in the keyboard or in the stand-alone reader, Ferrell adds.

The device indicated if the person was a first-time user from whom the hospital needed to capture a fingerprint, he explains. "If so, the person would make a swipe on the little hockey puck of the left and the right index finger, in case one couldn't be read."

The information on the smart card then printed an algorithmic reproduction of the fingerprint, which is "like a 99% match," Ferrell says. Registrars could see on the screen if it was "a good match and a good capture," he notes, and if not, would ask the patient to move his or her finger and do it again.

When the device was gathering the algorithm, there normally would be a red or green light indicating the result, Ferrell says, but during the pilot the user never knew if any given card was a match or not.

The pilot, he explains, was designed to be a test of the technology, so that any bugs could be worked out, and was not to be used to turn anyone away.

The way the technology is designed is that the transaction is recorded as a biometric match or failure, Ferrell says. "The data is stored on the back-end server and used for reporting and tracking fraudulent transactions."

Patients who had the cards were very receptive to the process, Ferrell adds. "From the patient's point of view," he points out, "being able to just pop this card out rather than pull out a big piece of paper [indicating Medicaid status] and have people say, 'Oh, they're on Medicaid,' was a positive experience."

The long-term goal of the Medicaid Integrity Pilot, Ferrell says, was to link various state programs — such as the food stamps program or the Women, Infant, Child program — to the same smartcard, thereby minimizing costs and increasing convenience to Medicaid recipients.

The process of checking smart cards and capturing fingerprints of Medicaid recipients was noticed and asked about by other patients, he notes. Simply knowing that such procedures are in place, Ferrell suggests, likely would serve as a deterrent to those who might otherwise try to use false identification.

(Editor's note: Jeff Ferrell can be reached at JeffFerrell@texashealth.org.) ■

ED, primary care clinic pilot program for uninsured

'Working poor' are focus of services

A pilot program under way in Tucson, AZ, aims to direct uninsured patients who show up for care in the hospital emergency department to a nearby primary and specialty care clinic where they can find an ongoing medical home, says **Nancy Johnson,** RN, PhD(c), executive director of St. Elizabeth of Hungary Clinic.

The clinic, which is celebrating its 45th anniversary, was recently recognized by the Arizona Department of Health Services as the "gold standard" for care of the uninsured in southern Arizona.

People who come to the St. Mary's Hospital

ED for conditions that are not emergencies because they have no regular provider and those who end up there because they are at the crisis point of an illness are the project's target population, adds Johnson, who also operates a consulting business called Quality Health Consultants with her physician husband.

"[ED staff] fax us every day a list of anybody who has come in for care that is uninsured, doesn't have a physician, and isn't an emergency," she says. "That's usually 12 to 15 people in a 24-hour period."

A staff member at the clinic calls the patients, explains how their names were obtained, and says something like, "We'd like to invite you over to establish St. Elizabeth as your medical home, a place to get care when there is not an emergency."

Patients at the clinic, which serves individuals who are not eligible for federal or state-funded health care programs, are put on a sliding scale and pay whatever they can afford, Johnson notes. "As a result, hopefully, the ED is seeing fewer uninsured people who are not emergency [cases]. ED care is very expensive and we want to make sure we have that for people who really need it.

"It's that idea of 'right person, right place, right service,'" she says.

"We're tracking what percentage of those people we can register for care, and what percentage actually keep their appointments," Johnson adds.

Cooperation between clinic and hospital staff is an ongoing focus at St. Elizabeth of Hungary, she says. "When one of our patients needs to have surgery for cancer, we call ahead to let the hospital know the person doesn't have insurance so they can be prepared to help rather that have it be a traumatic experience."

Clinic personnel work with hospitals to set up packages and payment plans for uninsured patients, Johnson adds. "It's a collaborative effort. We don't want people in the position of not seeking care because of fear of the system, that the cost will wipe them out [financially]."

One example is an arrangement with Tucson's University Hospital on obstetrics care, she explains.

Pregnant women without health insurance who don't qualify for government assistance are set up with a "package," whereby they make payments throughout the pregnancy, Johnson says. By the time the child is born, she adds, the payments are completed.

"It's a discounted total, but the flip side is that otherwise these women would just show up at the ED in labor with no [prenatal] care," Johnson points out. "The message here is that our staff work collaboratively with hospital registration and business staff, rather than letting things fall where they may."

Misconceptions about uninsured

Johnson says experience has shown her that most people — including many in the health care field — have a number of misconceptions regarding the uninsured population.

"People think [the uninsured] don't work, but in fact eight of 10 are working," she says. "These are the working poor. There are 46 million people in the country without health care coverage, and here in Arizona, there are usually at least a million people without it at any one time."

Another thing many people believe, Johnson notes, is that it doesn't really matter if one has health insurance because necessary care will be provided regardless.

In fact, the uninsured are much less likely to get care, even with serious symptoms, she says, citing a woman with breast cancer who knew she had a lump but delayed seeking care because she was concerned about her inability to pay.

Children without health care coverage, Johnson says, don't get care for things like asthma, ear infections and sore throats.

At a recent presentation on uninsured care she made to a group of case managers, she notes, many had some of the same misconceptions as the general public.

Exacerbating the situation, Johnson adds, is the fact that health care insurance premiums were expected to rise between 6.7% and 9.9% in 2006. The average increase in Arizona was 10%, she says.

The web site (www.covertheuninsuredweek.org) is an excellent resource for health care professionals, Johnson says. "If you go there, you can click on your state, and it tells you, in English and Spanish, what services are available for the uninsured, how to find health insurance, and how to get both public and private coverage.

"This is something we all need to be knowledgeable about," she adds, "if we want to keep our health care system as effective and efficient as possible."

(Editor's note: Nancy Johnson can be reached at njohnson@ccs-soaz.org.) ■

Attorney: 'Rotation' referrals may compromise care

DPs also cautioned about legal risks

Patients' right to freedom of choice of providers has been a source of continuing conflict, especially between hospitals and post-acute providers not owned by or affiliated with hospitals — so-called freestanding providers, notes **Elizabeth Hogue,** Esq., a Burtonsville, MD-based attorney specializing in health care issues.

Hospitals may be tempted to ease that tension, she adds, through a rotation system of referrals, whereby they assign patients who cannot or will not choose a provider to one on a list to receive referrals. Under such a system, Hogue says, each listed provider receives one referral before any provider receives another.

But while the rotation system is an appealing solution, she continues, it actually may compromise quality of care.

"First, many post-acute services are provided under the supervision of physicians based on their specific orders," Hogue explains. "Because physicians supervise these services, they are at risk for legal liability, along with providers and their staff members, if the providers and staff members do not meet applicable standards of care."

As a result, physicians have a clear interest in assuring the quality of care provided by post-acute providers to their patients, and so may choose to designate in their orders which provider will render those services, she says. "This helps to assure quality of care and manage their liability risks."

When physicians order services from a particular provider, Hogue points out, other providers — including discharge planners and case managers — may not ignore, alter, or delete any orders from patients' medical records. If these discharge planners and case managers are licensed nurses or social workers, she adds, they may be subject to discipline by state licensure boards if they modify orders from patients' physicians.

Some post-acute providers have developed specialty programs in orthopedics, respiratory services or palliative care, for example, Hogue notes. Quality of care received by patients who need services in these areas may be compromised, she suggests, if they are referred to providers that don't offer them when those who do provide these specialty programs are available in the area in which the patients live.

Hospitals' risk of liability may be significantly increased, she says, when specialty physicians order care from a provider that has a specialty program and those orders are ignored in favor of a system of referral rotation.

Whatever the situation, Hogue says, all providers are required to abide by patients' right to freedom of choice of providers, as she explains below.

1. All patients have a common law right based on court decisions to control the care provided to them including who renders it. When patients, regardless of payer source or type of care, voluntarily express preferences for providers, their choices must be honored.

2. Federal statutes of the Medicare and Medicaid programs guarantee beneficiaries and recipients of these programs the right to freedom of choice of providers, although Medicaid recipients who participate in a waiver program may have waived this right.

3. The Balanced Budget Act of 1997 (BBA) requires hospitals to develop a list of home health agencies that meet these criteria:

a. medicare certified;

b. provide services in the geographic areas where patients reside;

c. asked to be on the list.

If hospitals place on the list the names of agencies in which they have a financial interest that should be disclosed, the relationship between the hospital and the agency must be specified on the list, she adds. "This list must be presented to patients so they can choose the home health agency they wish to provide services to them."

If physicians have written orders for services from specific agencies, Hogue continues, case managers and discharge planners must tell patients about the orders when the list is presented to them and must tell patients they have the right to choose a different agency, if they wish.

4. Hospital Conditions of Participation (COPs) include the basic requirements of the BBA, described above. They also require discharge planners/case managers to develop an appropriate discharge plan for each patient.

The risk of legal liability for both hospitals and discharge planners/case managers may be increased, Hogue notes, when discharge planners/case managers fail to develop a plan that best meets patients' needs in favor of a system of rotation.

Patients are likely to accept the agencies ordered by their physicians, she adds. If, however, patients voluntarily express their preferences or choose an agency other than the one ordered by their attending physicians, Hogue says, patient choices "trump" physician orders and must be honored.

[Editor's note: Elizabeth Hogue may be reached at (301) 421-0143 or by e-mail at ehogue5@comcast.net.] ■

Don't delay, hospitals told, in getting ready for NPIs

Risks include lost, delayed reimbursement

Failure to adequately prepare for the advent of the National Provider Identifier (NPI) will have a significant impact on provider reimbursement, says **Beth Keith,** CHAM, senior management consultant for ACS Healthcare Solutions.

Rejected claims, delayed reimbursement, and potentially lost reimbursement will result, Keith cautions, if providers don't take the appropriate steps.

All health care providers covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), whether individuals or organizations, must obtain an NPI for use in identifying themselves in HIPAA standard transactions, she says.

A 10-digit numeric identifier that does not expire or change, the NPI must be used exclusively by May 23, 2007, to identify covered health care providers in standard health care transactions by HIPAA-covered entities, such as providers completing electronic transactions, health care clearinghouses, and large health plans. Small health plans must use only the NPI by May 23, 2008.

The identifier is used to ensure that medical claims are processed in a timely manner and payments are made correctly.

Keith advises hospitals to get ready for the change by making sure the following things have been done:

- NPI numbers have been obtained for all required providers;
- Existing provider master files have been cleaned and corrected;
- A crosswalk with NPI numbers and UPIN, payer identifiers, etc., for all providers has been mapped; and
- Dual NPA numbers and existing provider numbers are ready for testing claims submission to Medicare fiscal intermediaries, clearinghouses, and electronic billing vendors from Oct. 2, 2006, through May 22, 2007.

The change affects providers' information technology systems as well as their reimbursement, Keith points out, in that current claims-processing systems must accommodate the NPI identifier — in addition to current payer identifiers — from now until May 23, 2007.

"Following this initial implementation date," she adds, "the system must be prepared to switch completely to the NPI number by May 23, 2008, when small payers are required to comply with the ruling."

To facilitate the conversion, Keith points out, some organizations have volunteered to assist their medical staff through their medical staff credentialing offices. By assisting the physicians in obtaining these identifiers, she notes, these facilities have the data available for their IT system, which ensures their own success during the transition period.

"If your organization has not been involved in assisting your physicians in obtaining this important identifier," Keith says, "you must obtain these numbers from each medical staff member, enter them into your IT system, and validate their presence on the claim forms as of May 23, 2007."

It's advisable to get the number several months in advance so testing can be done between provider and payer systems to prevent any potential loss in reimbursement, she emphasizes. Following this initial effort, Keith suggests, providers should get the identifier as part of their physician credentialing information process.

[Editor's note: Beth Keith may be reached at Beth.Keith@acs-hcs.com. Health care providers can obtain their NPI by applying on-line at https://NPPES.cms.hhs.gov, calling (800) 465-3203 and requesting an application form, or applying for a bulk enumeration.] ■

Hospital UB-04 forms in use starting in March

Software changes may be necessary

While the impact of new hospital billing forms will be felt more by the business office than the front end, access personnel also

should be aware of the change, since the information they collect feeds into the billing system.

The new UB-04 medical claim form, which replaces the UB-92 form, will be available earlier in the year, but will not be accepted for billing until March 1, 2007. The form will be phased in over a transition period from March 1 to May 22, and used exclusively for hospital billing beginning May 23, 2007.

The UB-04 data set accommodates the National Provider Identifier (NPI) **(see related story, p. 9)** and incorporates a number of other changes and improvements. They are more in line with the 837 format.

Many of the data elements referenced in the UB-04 data set and corresponding manual are also used in the Health Insurance Portability and Accountability Act's electronic claim standard.

Providers that are submitting claims electronically should contact their software vendors well in advance of the deadline to find out what changes need to be made to their systems to allow for the new format, says **Michele Redmond,** co-owner of Solutions Medical Billing Inc.

Those submitting UB forms on paper should make sure their software is capable of printing the new UB-04 format, she adds. "Unless you recently upgraded your software, most likely it will need some changes."

Redmond suggests that providers look into the changes that need to be made right away to avoid glitches that could disrupt the organization's cash flow. ■

NY new regulations govern language assistance

Hospitals must designate coordinator

The state of New York has taken a step toward ensuring consistency in the provision of language assistance services to hospital patients with limited English proficiency (LEP).

New state regulations that took effect recently require hospitals to designate a coordinator to oversee language assistance services and conduct annual needs assessments to identify English-speaking populations in their service areas. They also specify requirements for ongoing education and training concerning cultural and linguistic competence for employees with direct patient care contact.

The state health commissioner, meanwhile, has proposed patient interpreter services as part of the new regulations, including a requirement that hospitals statewide create and implement formal Language Assistance Programs (LAPs). The programs, according to the proposal, will assure appropriate communication with patients on treatment options, informed consent, discharge plans, and health care proxy decisions.

Under this expanded process, hospitals will discourage the use of family members, as well as individuals under age 16, as interpreters, except in emergency situations.

While many of New York's hospitals have implemented policies and protocols to provide communication assistance to patients, the new regulations will bring uniformity to the process in hospitals statewide, proponents say.

A proposal by state Health Commissioner **Antonia C. Novella**, MD, MPH, aimed at ensuring that the standard of care is being met and that patients' rights are being protected, would require the state's hospitals to do the following:

- Create LAPs and name a language assistance coordinator who would oversee communication assistance services in the hospital and report to hospital administration;
- Implement policies that will assure the patient's communication needs and language preference are identified, confirmed, and documented in the front page of his or her medical record during the initial hospital visit;
- Post signage in entrance ways and common areas of the hospital offering free interpreter services;
- Provide continuing education and training to staff on the importance of delivering culturally and linguistically competent services, as well as how to access interpreter services on behalf of patients; and
- Conduct annual assessments of the linguistic needs of the population in the communities the hospital serves and evaluate whether those needs are being met.

Title IV of the Civil Rights Act and state regulations require hospitals to provide interpretation services to patients with difficulty speaking English or who have disabilities affecting their communication. ■

Proposed discharge change less oppressive in final form

Rule requires 'Important Message' revision

A potentially onerous hospital discharge rule proposed in April 2006 by the Centers for Medicare & Medicaid Services (CMS) is significantly less burdensome in its final form.

The new rule, released Nov. 29, 2006, will require hospitals to issue a revised version of the Important Message from Medicare that fully explains patients' discharge rights. Rather than issuing a second and different notice 24 hours before discharge as was proposed, hospitals will issue the Important Message within two days of admission, answer any questions, and get the signature of the patient or his or her representative on the notice.

Hospitals will be required to provide a copy of the signed notice before the patient leaves the hospital, but not more than two days before the departure. For short stays, this means the copy of the notice need be provided only once.

CMS has said that it will be developing the revised notice text, but before submitting it to the Office of Management and Budget for public comment and paperwork clearance will test it with beneficiary focus groups. The rule becomes effective July 1, 2007.

Opponents of the proposed rule had noted that it would add more bureaucracy to an already complicated and confusing discharge process for a patient population — generally more than age 65 — that needs assistance and guidance.

Proponents, meanwhile, had contended that the Important Message is not timely notice because it is not issued close enough to discharge.

The American Hospital Association (AHA) had expressed several concerns about the proposed rule, including that it would have the unintended consequence of unnecessarily extending the hospital stays of Medicare patients by an extra day because hospitals often cannot predict the date of discharge one day in advance.

"By requiring that [the notice] be rendered after the discharge decision is made and yet 24 hours before discharge, you end up in many cases keeping people another day," noted **Ellen Pryga,** AHA's director of public policy development. "With diagnosis-related groups, hospitals don't get paid for that."

Another concern was that the proposal was written in an "alarmist" way, Pryga said not long after it was issued. She said it would have created the impression that it was likely the patient would be sent home too soon and should automatically be asking a quality improvement organization to review the decision.

In other action, CMS has finalized its proposal to relax four requirements or conditions that hospitals must meet to participate in the Medicare and Medicaid programs.

That final rule, effective Jan. 26, 2007, gives hospitals up to 30 days before a patient's admission or 24 hours after admission to complete a medical history and physical examination, and allows more health care professionals to perform the exam. The record of the exam must be entered into the patient's medical record within 24 hours after admission.

In addition, the rule provides that all verbal orders given by a medical professional must be recorded within 48 hours in the patient's record by the medical professional or another practitioner responsible for the patient's care.

Previously, verbal orders could be entered in the medical record only by the physician who issued them.

The regulation also requires hospitals to secure all drugs and biologicals and, finally, permits any individual who is qualified to administer anesthesia, rather than just the person who administered it, to conduct the post-anesthesia evaluation. ■

Report shows hospitals support P4P program

Almost all hospitals support the Centers for Medicare & Medicaid Services (CMS) in moving forward with a pay-for-performance pro-

COMING IN FUTURE MONTHS

- Successful access, nursing collaborations
- 13-hospital patient intake center
- Staff turnover reexamined
- Climbing the access career ladder

gram over the next few years, but selecting the right measures will be a critical element of future success, according to a new report by Mathematica Policy Research.

The findings are based on a 2005 survey of hospital executives that Mathematica conducted for CMS, which explored hospitals' views on a future CMS pay-for-performance initiative and the quality measures it should include.

Most hospitals participating in the Hospital Quality Alliance supported using that program's original 10 measures or a slightly expanded set of measures, while most hospitals participating in the CMS/Premier Hospital Quality Incentive Demonstration favored using or expanding that program's 35 measures.

"In choosing measures, CMS will need to strike a balance between including a large number of measures to estimate hospital quality accurately in important clinical areas, and overwhelming hospitals with new measures they have not been reporting," said lead author Suzanne Felt-Lisk. ▼

AHIP plan would expand SCIP, Medicaid coverage

A plan recently announced by America's Health Insurance Plans (AHIP) would expand the State Children's Health Insurance Program (SCHIP) to all uninsured children from families with incomes less than 200% of the federal poverty level and Medicaid to all uninsured adults with incomes less than 100% of the FPL.

Under the proposal, all children would have access to health insurance within three years, and 95% of adults would have access within 10 years, at an estimated cost to the federal government of $300 billion, according to AHIP.

The plan also would establish a "universal health account" that allows individuals to purchase any type of health coverage and pay for qualified medical expenses with pre-tax dollars. In addition, it provides for a tax credit of up to $500 for low-income families that secure health insurance for their children, and a $50 billion federal grant to help states expand access to coverage. ■