

Hospital Access Management™

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



Put a stop to needless claims denials: ID root causes in people and processes

You'll need to look at training, technology, and process redesign

IN THIS ISSUE

- Learn whether your claims denials are caused by human error or a bad process . . . cover
- Even small leadership roles can make staff think twice before leaving access 5
- Reduce your turnover by ignoring these myths about patient access staff 7
- What can a POS pricing system do for you? 8
- Consider these pros — and also potential cons — of giving patients price estimates 10
- How to stop incorrect patient access data from causing harm 11
- A way to cut registration delays with minimal training needed for staff 12

**Also included:
2008 Salary Survey Report**

JANUARY 2009

VOL. 28, NO. 1 • (pages 1-12)

Benefits exhausted, coverage not in effect at the time of service, patient ineligible at the time of service, no authorization prior to service, and patient unidentified. Each of these reasons for a denied claim is different, but the result is the same — the hospital doesn't collect. And in today's economy, this spells trouble for patient access departments. Instead of "fixing" claims denials in the business office, a better approach is to avoid the denials in the first place.

Previously, hospitals recognized that claims needed to be "scrubbed" before they went out the door," says **Katherine Murphy**, CHAM, director of access services for Nebo Systems, a subsidiary of Passport Health Communications in Oakbrook Terrace, IL. "Now we are recognizing they need to be scrubbed before they go to the back end, for a final blessing so to speak," she says.

Sue Green, MBA, vice president of revenue cycle at St. Luke's Episcopal Health System in Houston, says, "the big issues for us are to ensure accuracy, eligibility, and medical necessity up front."

Green says the organization is redesigning processes to prevent deniable admissions such as orders written pre-surgery and inpatient admissions for outpatient procedures.

"You really do need software to manage denials, in order to be able to drill down into root causes and prevent them in the future," she says. "These days, people are not just buying software that accounts for denials, but an application that integrates data all along the revenue cycle."

St. Luke's is in the process of implementing new denials management software to replace an old application that was developed years ago, says Green.

However, technology can't stop denials caused by human error. For this reason, a lot of effort at St. Luke's goes into training registration staff about how they affect the ability to submit a "clean" claim, says Green. "We are trying to teach them about the whole cycle, so they have

**NOW AVAILABLE ON-LINE! www.ahcmedia.com/online.html
For more information, call toll-free (800) 688-2421.**

a context to understand their job.”

The core training program for patient access is three weeks and covers customer service, the revenue cycle, necessary applications, government compliance issues, legal issues such as the Emergency Medical Treatment and Labor Act, managed care basics, and reimbursement basics.

“Staff are not granted access to our system without completion,” says Green. “Staff are then given further specialized training and mentoring with a seasoned staff member.”

Still, Green says that the underlying reason that claims are denied is “more often processes, not people.”

For example, an organization may not have a defined process for real-time review of orders after what was anticipated to be outpatient surgery. If the patient becomes an observation patient or is admitted as an inpatient, there must be a process to ensure compliance and authorization as that decision is being made.

Retrospective review too late

“Retrospective review will result in denials, since it is too late to intervene effectively,” says Green. “The knowledge needed from the first contact with the patient has multiplied significantly. This is really crucial as the economy tightens.”

The goal is to partner with patients, says Green, so they understand what their cost will be and what resources they have to help pay for their health care.

“Also, most people have become more aggressive about appealing claims,” says Green. “We used to accept denials if we erred. But now, if we miss a deadline, for example, and get a ‘technical’ denial, we appeal. If we provided the appropriate care, the payer should reimburse. We will elevate the denial to receive payment whenever possible.”

The person who processed the account originally is the one who “works” the denial in order to enhance accountability and organizational learning. “We have seen an increase in payer-related issues,” says **Connie Renfro**, director of patient financial services at St. Luke’s. “They may not have their own database up to date but will pay the claim if it is appealed.”

About five years ago, St. Luke’s formed a call center to centralize access, which performs preservice activities such as scheduling, pre-registration, eligibility checks, and obtaining authorizations.

“This allows for greater standardization of those processes and a single access point,” says Green. “We use software to allow registrars to scrub their work in real-time to increase accuracy, aiming for the right patient, the right care, and the right authorization.”

Analyze root causes

In January 2008, Cypress Fairbanks Medical Center in Houston was averaging \$130,000 in disputed denials. In September 2008, these denials were at \$50,000 a month.

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 and at additional mailing offices.

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. Add \$17.95 for shipping & handling. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. 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.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact AHC Media LLC. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcmedia.com>.

Editorial Questions

Call **Jill Robbins**
at (404) 262-5557

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for

general guidance only; professional counsel should be sought for specific situations.

Editor: **Stacey Kusterbeck**, (631) 425-9760.
Associate Publisher: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Copyright © 2008 by AHC Media LLC. **Hospital Access Management™** is a trademark of AHC Media LLC. The trademark **Hospital Access Management™** is used herein under license.



The organization used a “three-pronged approach” to achieve this impressive result: people, process and technology, says **Tony Lovett**, MBA, CHAM, director of patient access services. (See sidebar on claims denials due to employee errors below.)

First, patient access staff tracked the errors that ultimately led to denial write offs, and analyzed

the root causes of those errors. “Our analysis quickly illustrated that our problem involved one of the three issues,” says Lovett.

Lovett pulls the disputed denials report for his department each month. “My team then goes through each account,” says Lovett. “We read all of the documentation on the account, we review all scanned items on the account, and we listen

Stop needless denials, re-train employees

In their quest to reduce claims denials, one important component for patient access professionals at Cypress Fairbanks Medical Center in Houston was to “ensure that we had the right fit for the right job,” says **Tony Lovett**, MBA, CHAM, director of patient access services. “Patient access is fast-paced and can be tedious and difficult.”

First, Lovett clearly outlined the specific tasks a patient access representative was responsible for doing. “We created a job ladder that demonstrated what attributes and duties were meant for new hires; second-tier representatives; supervisors; and, finally, managers,” he says.

The next step was to find the right people for the right roles, which included developing some of the hospital’s employees for growth opportunities.

At Carolinas Medical Center, any training issues identified are taken back to the patient financial services training department and the patient access management team, who then deliver training to the frontline staff.

For example, some denials occurred because staff were not aware of Cobra coverage. Staff were re-trained to ask additional questions that would uncover the fact the patient was covered under a Cobra plan.

Also, a process for Blue Cross/Blue Shield radiology denials had to be developed, due to no authorization from the center’s vendor, AIM. “This involved specific items for the pre-service area, as well as the front-line staff at the facility,” says **Katie M. Davis**, director of patient financial services.

As a result of Blue Cross/Blue Shield of North Carolina requiring prior plan approval obtained by the physician’s office for outpatient high-tech diagnostic services, these procedures must have an approval number three days prior to the scheduled service, or be submitted by pre-service for re-schedule to radiology centralized scheduling.

At Cypress, an interdisciplinary revenue cycle committee meets monthly. On that committee sits the hospital’s CFO, business office director, patient access director, case management director, medical records director, and appeals coordinator.

Monthly review

“Each month, we review and analyze our respective denials and discuss trends and opportunities,” says Lovett. “We have found it helpful to have this joint discussion, as many of our issues overlap and involve our respective departments.”

At times, the committee also includes other areas that may contribute toward denials, from the clinical or departmental side of operations. “Many times, we have discovered that staff from each of the respective areas are in need of training,” says Lovett.

The physical therapy department, for example, recently had a department-specific meeting and discovered that their staff needed training on denial prevention and billing procedures. Similarly, patient access staff needed additional training with workers’ compensation practices, as well as job coaching for the correct assignment of insurance plan codes.

Davis says that any denial that can be tracked to an employee results in the employee not receiving incentive for the month the denial occurred. “If errors continue, we follow our disciplinary process,” she says.

One example of this is with insurance verification. If the registrar fails to verify the policy number and the claim is denied because of an incorrect policy number, the registrar who completed the insurance verification would be credited with the denial.

“We have the ability to listen to the phone calls, so we can hear if the registrar asked and did not document, or if they did not ask,” says Davis. “The registrar would lose their monthly incentive, which is based on a number of key performance indicators. The employee has the potential to lose up to \$450.00.” ■

to all recorded transactions on the account.”

From that exhaustive review, one of the “three-pronged” reasons is identified — people, process, or technology. The next step is to determine the root cause and the employee responsible for the error.

“We look for patterns regarding type of accounts, payers, work groups, and employees,” says Lovett. “We then develop a tactical action plan to address each issue per grouping.”

This past year, a problem was identified with the hospital’s physical therapy (PT) accounts. At the facility, PT accounts are registered as recurring accounts. After 30 days, these accounts are automatically re-registered.

“As a result of this automated system, the accounts were not touched by my employees, and the PT staff were not ensuring correct documentation to ensure authorization and prevent denials,” says Lovett. “Because of our analysis, we were able to close that gap and prevent further loss.”

The department had to “take a step back and look at our overall process before we could zoom in to the small step of each process,” says Lovett. “We had some overlooked areas that created gaps in which denials could sneak by us. We closed the gaps, and cemented those gaps with necessary and strategic redundancy.” For example, both the quality assurance coordinator and the denials coordinator now audit accounts.

Monitor trends closely

Denials have been approached in several different ways at Carolinas Medical Center in Charlotte, NC, says **Cassandra Lowery**, director of patient access. “Patient access is an essential member of Carolinas HealthCare System’s denial management team. We are very passionate about preventing denials,” she says.

The denial management department is a part of patient financial services and is made up of representatives from patient access, clinical care management, patient accounting, and radiology scheduling.

First, patient access reviews accounts to determine if the denial is due to an employee error or a process problem. If it is an employee error, the employee is re-trained.

The hospital’s denial management team runs reports based on specific denial codes. These codes reflect the area that could have had an

impact on the denial, such as patient access, clinical care management, or contracting.

“We receive the report and review the accounts that are in our scope, to see if we could have done something to prevent the denial,” says Lowery.

Suggested process changes

Changes to processes are made, depending on the trends found each month. “We constantly review and make changes to our processes to be sure we are doing all we can to prevent a denial,” says **Katie M. Davis**, director of patient financial services.

Here are proven strategies to reduce denials:

- **Develop a better process with your hospital’s financial counseling department.**

“We developed a process where they place any insurance they find on our online admission log for us to verify, as well as placing the insurance information on the account,” says Davis.

- **Create a web site to communicate more effectively with front-line staff.**

“Upcoming changes, such as insurance cards and the plan codes that are attached to them, can be broadcast to the entire staff at one time,” says Davis.

- **Work with your hospital’s information services (IS) team to develop reports that show accounts requiring authorization.**

“Our process for developing reports starts with an online service request, detailing what we want the report to show,” says Davis.

The report is assigned to a member of the IS patient management team, who works as a go-between with the requestor and the programmer to get to the end result. For instance, before the health system opened the new Levine’s Children’s Hospital, IS was asked to add the new patient types to insurance verification and follow-up reports.

Reports also were developed showing accounts that require authorization, which are scheduled up to three days in advance. “The report is then used to be sure we obtain the authorizations,” says Davis.

- **Use software to prove that contacts with payers were made.**

At Cypress Fairbanks Medical Center, patient access was looking to “adopt technology that would partner with us in our overall pursuit of denial nirvana,” says Lovett.

One big problem causing denials was that

physicians, payers, and patients were denying the fact that Lovett's pre-registration and insurance verification team were making the necessary contacts. Patient access staff had no way to prove this had been done.

The organization implemented the Trace system (manufactured by The White Stone Group, based in Knoxville, TN) as a solution. "We quickly adopted each of the tools offered to us with Trace. We now capture all incoming and outgoing payer, physician, and patient transactions," says Lovett. These interactions are now recorded, as proof that, indeed, the contacts were made.

- **Hire on-site representatives to supplement patient access staff.**

At Baptist Health System in Birmingham, AL, denials stemmed largely from staffing, due to turnover, the Family and Medical Leave Act, and FTE reductions.

"The preregistration team was our 'go to' area for staffing in registration when we would find ourselves without sufficient coverage," says **Betty McCulley**, CHAM, hospital liaison for patient access/consolidated business office. "We took a different approach at our four-hospital health system."

The health system found a company that provides on-site representatives who preregister, preauthorize for both the physician and the hospital, screen for medical necessity, verify coverage, call to inform the patient of his or her financial out-of-pocket responsibility preservice, and collect from those who are willing to pay over the phone.

"There is one rep from this company at each facility. They do not replace our staff — they enhance our preregistration and precertification resources," says McCulley.

[For more information, contact:

Katie M. Davis, director, patient financial services, Carolinas Medical Center, Charlotte, NC. Phone: (704) 512-7181. E-mail: Katie.Davis@carolinashealthcare.org.

Sue Green, MBA, vice president, revenue cycle, St. Luke's Episcopal Health System, Houston, TX. Phone: (832) 355-1000. E-mail: sgreen3@sleh.com.

Cassandra Lowery, director, patient access, Carolinas Medical Center, Charlotte, NC. E-mail: Cassandra.Lowery@carolinashealthcare.org.

Tony Lovett, MBA, CHAM, director, patient access services, Cypress Fairbanks Medical Center, Houston, TX. E-mail: Tony.Lovett@tenethealth.com.

Betty McCulley, CHAM, hospital liaison, patient access/consolidated business office, Baptist Health System, Birmingham, AL. Phone: (205) 599-4122. E-mail: Betty.McCulley@bhsala.com.

Katherine Murphy, CHAM, director of access services, Nebo Systems, 1 South 376 Summit Ave., Court B, Oakbrook Terrace, IL 60181-3985. Phone: (630) 916-8818 ext. 34. E-mail: katherine@Nebo.com] ■