Certified Healthcare Access Associate Study Guide

National Association of Healthcare Access Management
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Dear CHAA Candidate,

It is time to make a difference in your career, your workplace and in the industry, and one of the best ways to do this is to become a Certified Healthcare Access Associate (CHAA). The commitment you make to apply, prepare and take the examination demonstrates a well-prepared, highly motivated employee. Our standards are high, but so are yours.

Becoming a CHAA demonstrates professional achievement in Patient Access services. Your supervisors and colleagues recognize the importance of this credential. But there are even more reasons for you to earn your CHAA. Many job postings are now requesting CHAA certification in order to move into frontline supervisory positions. You will stand out among the rest by demonstrating that you have made a difference in your career. Experience the personal pride of accomplishment in attaining your goal of being a Certified Healthcare Access Associate. It's dynamic and rewarding.

The information in this document is not an all-inclusive review of the content of the CHAA examination but should assist you in your preparation. Best wishes for success to you on your journey to becoming a Certified Healthcare Access Associate.

The Education Committee of NAHAM

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ABOUT NAHAM

The National Association of Healthcare Access Management (NAHAM) is the only national professional organization dedicated to promoting excellence in the management of Patient Access services in all areas of the healthcare delivery system. We establish best practices and subject matter expertise; provide an array of networking, education and certification opportunities; and enable our members to influence and promote high-quality delivery of Patient Access services.

Patient Access services professionals provide quality services in registration and all of its support processes to patients, providers and payers into, through and out of their healthcare experience. Patient Access services includes: admissions, call centers, scheduling, registration, patient finance, guest relations and other related services.

NAHAM is *the* source for valuable education and support on issues impacting Patient Access services.

CANDIDATE RESPONSIBLITIES

It is the responsibility of the candidate to read the entire contents of the Candidate Guide to Certification *before applying for the examination*. The Candidate Guide to Certification contains current information about the policies and procedures of the NAHAM certification program.

It is the responsibility of the candidate to know of all deadlines associated with the certification process. Late registrations will not be accepted.

It is the responsibility of the candidate to confirm a qualified proctor. NAHAM is not responsible for selecting or scheduling proctors for examination candidates.

It is the responsibility of the candidate to understand the Certification Maintenance program and meet applicable deadlines to keep his or her certification active.

Examination Preparation

The NAHAM Certification Commission offers the following suggestions for preparing for the test.

Review the applicable examination content outline and ask yourself the following questions:

- Do I have a good understanding of the content areas?
- Do I use this knowledge area regularly at work?

Plan your studying based on your answers to these questions. For example, for content areas you have a good understanding of and use every day, you may only need to do a quick review to prepare for the test, whereas in areas in which you are less familiar, you may decide that you need more in-depth studying or training before taking the test. Some individuals may simply not be at the point whereby they will be successful testing and may wish to consider waiting to apply until they feel more prepared.

When planning your studying, you should think about what percentage of the test questions will cover each major content area. If you are not very familiar with a content area that will include a significant proportion of the test questions, you probably should spend some additional time studying this area.

There are many resources available to candidates as they prepare for the CHAA examination. One's education and practical work experience are certainly included in the body of resources key to success. This Study Guide is but one resource and should *not* be the only material reviewed in preparation for the examination. Candidates are strongly encouraged to approach studying holistically – reviewing current literature, participating in instructor-led courses such as at the NAHAM Annual Conference, attending hospital in-service training, and forming study groups, to name just a few methods of preparation. No test questions are directly taken from the NAHAM Study Guide.

THE CERTIFICATION PROCESS

Examinations are administered four times annually for one full month: January, April, July and October. **Applications must be received a minimum of one month prior to the start of the testing month**. Proctor information must be included on the application. NAHAM will notify the candidate and proctor of the candidate's examination application status at least two weeks before the desired testing window.

Testing will be done at a suitable location agreed upon by you and your proctor. Official examination results will be sent to the candidate within eight weeks of the test date. Successful candidates will receive a pass letter and certificate.

If a candidate does not pass an examination during their first attempt, they may opt to retake the examination for an additional fee. Retake examinations may not be taken in the same testing period as the first attempt. **All retake examinations must be administered in the next consecutive quarter**. Candidates who are not successful with a retake examination and wish to continue to pursue certification will need to reapply and pay the applicable examination fees.

To maintain CHAA certified status, all certificants must renew their certification every two years. Failure to renew your certification will result in an “inactive” status.

Scope of the CHAA Examination

The CHAA examination is a 115-question multiple choice examination designed to test and challenge the candidate’s knowledge of and experience in the field of Patient Access services. The CHAA examination is designed to test associate-level individuals.

The CHAA examination is two hours long and proctored. The examination is Internet-based.

The composition of the CHAA examination is guided by extensive research on the job tasks performed and knowledge needed by those working in Patient Access services. Please note that the questions form each content area will be mixed throughout the examinations. The questions will not be presented in the order listed on the content outline.

The following is a detailed outline of the major content areas that will be used to guide the composition of the CHAA examination effective October 2017, with an indication (in parentheses) of the approximate percentage of the test devoted to each area.

Domain I: Patient Access Foundations (44% of Examination)

1) **Customer Experience**
    a) Customer Assessment
        i) Identify customer expectations and concerns (e.g., confidentiality, emotional, spiritual)
        ii) Identify clinical concerns and patient needs
        iii) Identify financial concerns and patient needs
        iv) Arrange customer literacy and comprehension services (e.g., interpreter services, meaningful use data)
    b) Quality and Customer Service
        i) Employ strategies to deliver quality services and customer satisfaction (i.e., in-person and remotely)
        ii) Interpret results from customer satisfaction metrics (e.g., HCAHPS, patient satisfaction survey)
        iii) Recognize the purpose of benchmark processes to improve outcomes
        iv) Recommend process and quality improvement initiatives
        v) Comprehend key performance indicators (KPIs), best practices and dashboards
        vi) Employ principles of effective communication (e.g., written, verbal, age appropriate)
        vii) Utilize national patient safety guidelines (e.g., two patient identifiers, physical safety)

2) **Regulatory Compliance**
   a) Recognize requirements of OIG (e.g., EMTALA, patient's rights and responsibilities, advanced directives)
   b) Recognize requirements for CMS (e.g., HIPAA, IMM, MSP, ABN, Condition Code 44, fraud and abuse)
   c) Comprehend accreditation guidelines (e.g., Joint Commission, DNV-GL)
   d) Recognize requirements for other government agencies (e.g., TRICARE, VA, Medicaid)
3) **Revenue Cycle**
   a) Identify data elements necessary for accurate billing (e.g., occurrence codes, condition codes, diagnosis, CPT)
   b) Comprehend billing indicators for the UB-04 and CMS 1500 billing forms
   c) Verify payer plan coverage (e.g., governmental payers, third party liability, insurance eligibility)
   d) Comprehend the effects of the Affordable Care Act (e.g., HMO, PPO, POS, the exchange)
   e) Determine coordination of benefits
   f) Perform point-of-service collection
   g) Provide and coordinate financial counseling
   h) Comprehend medical terminology and coding
   i) Collaborate with health information management (e.g., prevent duplicate medical records)
   j) Collaborate with patient financial services (e.g., billing, accounts receivable)
   k) Mitigate denials
4) **Information Systems**
   a) Manage timely input of data
   b) Comprehend impact of patient management system transactions (e.g., electronic data interface, electronic medical records and ancillary systems)
   c) Recognize purpose for down-time or mass casualty procedures and reconciliation
5) **Resource Management**
   a) Recognize need for resource management (e.g., staff, time, equipment, funds)
   b) Interpret quality metrics and productivity data

Domain II: Pre-arrival (31% of Examination)

1) Scheduling
   a) Identify accurate patient and record pertinent schedule information
   b) Arrange and schedule location, equipment and/or staff (resources)
   c) Identify insurance information required to schedule service (e.g., authorization, medical policy, referrals)
   d) Identify clinical information required to confirm service for a specific date and time (e.g., referrals, valid order)

2) Pre-registration

a) Patient Information

i) Utilize the electronic master patient index (EMPI) to ensure accurate patient identification and safety

ii) Collect and record patient information (e.g., patient and guarantor demographics)

b) Perform financial clearance

i) Identify and collect accurate payer information and subscriber demographics

ii) Verify eligibility and interpret benefits

iii) Validate and meet payer requirements

iv) Secure prior authorization

v) Inform and/or collect customer financial obligations prior to service

(1) Explain estimates and make payment arrangements

(2) Screen for other state or federal program eligibility and/or identify need for financial assistance

c) Patient and family education

i) Identify testing and procedure prerequisites (e.g., blood work, fasting, stop medication)

ii) Review service or procedure information with patient

iii) Review wayfinding (e.g., parking, valet, facility maps)

Domain III: Arrival (25% of Examination)

1) Patient Check-in, Admission, Registration

a) Validate patient class order (e.g., inpatient, observation, outpatient, ED)

b) Explain and execute patient registration forms (e.g., The Patient Bill of Rights and Responsibilities, HIPAA, consents, other required documents)

c) Validate demographics, admission source, and clinical and financial information

d) Validate patient identification, order and insurance validation

e) Validate ordered levels of care (e.g., ICU, PCU and telemetry)

f) Indicate value of patient portal

2) Patient and Family Experience

a) Identify services to help reduce patient and family stress and increase customer satisfaction

b) Indicate internal wayfinding (e.g., transport and facility signage)

c) Identify relevant information to provide to patient and family (room number, visiting hours, etc.)

d) Manage patient tracking (e.g., locating, transporting, routing)

e) Recognize service recovery opportunities (e.g., validating parking and free meal tickets)

3) Bed Management

a) Knowledge of information concerning patient placement

b) Validate patient status change orders (e.g., observation to in-patient)

c) Collaborate with case management (e.g., status changes)

Patient Access Foundations

CUSTOMER EXPERIENCE

Customer Assessment

In this chapter, the student will learn to:

- Identify customer expectations and concerns (e.g., confidentiality, emotional, spiritual)
- Identify clinical concerns and patient needs
- Identify financial concerns and patient needs
- Arrange customer literacy and comprehension services (e.g., interpreter services, meaningful use data)
- Identify tools and KPIs to measure customer experience

Key Terms

- Meaningful Use
- Preferred Language
- HCAHPS
- Key Performance Indicators
- Patient Satisfaction Surveys
- Effective Listening
- HEAT
- Quality Improvement Initiatives
- Electronic Health Records (EHR)
- Benchmarking

Patient Expectations and Concerns

Hospitals provide medical care regardless of race, creed, color, sex, national origin, sexual orientation, disability, age or the ability to pay. We respect the medical needs of all people who come to our doors and the financial concerns of those with limited resources.

Patients will often have emotional and spiritual needs during their time of care. It is every hospital employee's responsibility to recognize these needs and refer the patient to the appropriate staff who can assist with their needs, most often the healthcare provider or pastoral care.

Identifying Clinical Concerns

Patients will arrive with many clinical concerns. Answer only the questions related to your job function and refer the patient to appropriate staff to answer their remaining concerns. General types of questions you will ask are:

- Name, address, phone, fax, email, etc.

- Primary physician, specialists and their addresses and phone numbers if possible
- Insurance information (copy of card if possible)
- Medical problem or what procedure they are having
- Prep information provided by the physician or department
- Last visit information
- Financial responsibility for deductibles and co-pays, etc.
- Special needs according to ADA guidelines
- Language barriers

Identifying Financial Concerns

Hospital personnel are experienced in working with insurance companies and government agencies and should assist patients in determining how accounts are to be paid. This includes coordinating benefits with payers, point of service payments, payment arrangements, and/or charity care.

If enrolled in Medicare or Medicaid, the patient should present a current identification card at the time of registration. This information may also be obtained via the website. If the patient is not enrolled, but thinks that he or she may be eligible, hospital personnel should refer the patient as appropriate to state officials for eligibility.

Patients should demonstrate an understanding of co-payments, deductibles and other financial issues as well as how to get additional information if required. This can be demonstrated by the patient's responses and evaluation of outcomes.

Special Needs of Patients

In today's healthcare environment, Patient Access staff must assess special needs during the initial patient encounter. The physician order is a good source of information on determining special needs such as a private room, specific bed type or other clinical indications, but Patient Access staff must also be aware of other special needs and the requirements associated with those needs.

Language barriers must be identified and accommodated. Under Title III of the American with Disabilities Act (ADA), hospitals are required to communicate effectively with patients, family members and visitors who are hard-of-hearing, and must take reasonable steps to provide meaningful access to persons with limited English proficiency (LEP). As point of first contact, it is necessary for Patient Access staff members to identify communication barriers for not only patients but for family members and visitors. Resources to eliminate communication barriers must be identified and utilized. A patient's preferred language must also be documented in the patient registration system. It not only assists other care

givers on how the patient wishes to communicate but also meets requirements for Meaningful Use, a government standard for use of an electronic medical record.

It is important to check that the patient understands the information you are giving. Asking questions not only lets you know when they understand, but also gives the patient permission to speak up and participate in the interview. Below are some ways you can check for understanding:

- "Does what I've said make sense to you?"
- "How can I make things clearer?"
- "Can you tell me what you understand so far?"
- "What is your understanding of what we just discussed?"
- Provide patient liability in writing to the patient

Some patients may nod in agreement or say they understand when they really do not. By asking the patient to repeat their understanding in their own words, you can determine whether further explanation is necessary.

By taking pacing and timing cues from your patient, you encourage a patient-centered interview that promotes patient communication.

Hospitals must also accommodate obese patients and visitors. Waiting room chairs, special beds and large wheelchairs are important to preserve the safety, dignity and comfort of a larger patient and visitors. In addition, staff should be educated on back safety to prevent injury when assisting patients in wheelchairs.

Quality and Customer Service

Most organizations recognize that excellence in service is an essential part of providing high-quality healthcare. Impressions about a facility's service levels are the result of staff behavior and attitude. In Patient Access services, the customer is not limited to the patient. Customers are also physicians and physician office staff, internal departments and employees, visitors, clergy, third party payers and suppliers.

Strategies to Deliver Quality Service and Customer Satisfaction

Traditional concerns such as waits and delays in service, proper room and food temperature, noise levels and pleasant smiles are all factors related to customer satisfaction. In addition, patients are taking a proactive approach to the financing of healthcare and becoming active participants not only in clinical decisions but also the financial decisions related to their own healthcare; patients are active consumers of healthcare. Therefore, Patient Access staff members must not only demonstrate the ability to provide

timely and accurate registration services but also be able to demonstrate a high level of understanding about third-party payer requirements, out-of-pocket expenses, financial assistance programs, and government regulations and guidelines and communicate this information to the patient.

Patient Access employees who work remotely must also employ these same techniques, many times over the telephone as they are speaking with patients and their families. The same customer service standards must be met for not only in-person interviews but also interviews conducted over the telephone.

Patients expect Patient Access associates to:

- Be technically competent
- Show compassion
- Keep them and their families/friends informed about procedures, test, treatments, etc.
- Be sensitive to the inconvenience and stress that result from health problems
- Protect privacy
- Anticipate individual needs and respond accordingly
- Use terms and language they can understand
- Be an informative, sole resource
- Know the organization's values
- Make a personal connection
- Show enthusiasm
- Practice the AIDET technique: Acknowledge, Introduce, Duration, Explanation and Thanks

Compassion is as significant as competence in creating a positive healthcare experience for the patient.

- Specific behaviors, such as smiling and making eye contact, demonstrate compassion and show the patient genuine care and concern.
- In addition, patients expect to be addressed appropriately. Slang terms such as "honey" or "sweetie" are not appropriate and demean the patient. Instead, ask the patient their preferred way to be addressed.
- Additional behaviors such as allowing patients and visitors to step off the elevator before entering, escorting patients and visitors and not pointing the way, and anticipating customer needs positively impact the experience of the customers.

In addition to the patients and visitors, other departments and employees are also customers of Patient Access. All departments and employees have the same goal: a positive patient experience. Patient

Access is part of this collaborative patient care process. To be a successful member of the patient care team, staff members must demonstrate creativity and flexibility and accept responsibility for problem identification and resolution.

Customer Satisfaction Results

There are two methods for obtaining customer feedback: active and passive.

- Active customer feedback occurs when the provider requests information from the patient.
- Passive customer feedback is the formal and informal process of obtaining and responding to patient compliments and concerns.

Actively soliciting customer feedback can be done by:

- Customer surveys
- Customer comment cards
- Customer callback programs

Passively soliciting customer feedback can be done by:

- Reviewing letters from patients and families
- Conversations with patients/families

Patient Access message to the patient:

- Notify the patient that they will receive a survey to rate their visit
- Make sure the patient knows the PA rep's name

Both positive and negative feedback have a purpose in healthcare surveys. Positive feedback is an opportunity to practice positive employee engagement and gain market share (customers). Negative feedback is an opportunity to apply quality improvement principles within the organization and to respond to the feedback with a service recovery effort as well as develop action plans to address issues.

Patient Satisfaction Surveys

Surveys are the best method to actively find out if a customer is satisfied. Patient satisfaction surveys can be written or verbal. The questions, the timing and the frequency of surveys all are important, but most important is how the information is used. It is important to conduct the patient satisfaction survey soon after the healthcare encounter when the experience is still fresh in the patient's mind.

Surveys are used within individual healthcare organizations to measure satisfaction and engage in quality improvement initiatives. Healthcare consumers and health insurance companies also use customer satisfaction surveys. Healthcare consumers are demanding more information on where to seek

services and are turning to published healthcare surveys to find organizations that meet or exceed expectations. Many health insurance companies have service excellence programs and are moving toward pay for performance reimbursement methodologies or allowing members to seek specific specialty services only at healthcare organizations that meet or exceed a level of performance benchmark.

Healthcare organizations recognize the need to participate with and publish survey results. Survey organizations such as JD Power and Press Ganey provide patient service satisfaction surveys that are used for both public relations (positive scores) and performance improvement (negative scores). Surveys may be tailored to provide feedback on specialty services or broad to encompass large populations of patients in both the inpatient and outpatient settings.

Types of surveys:

- Face to face
- Telephone survey
- Mail-in questionnaire
- E-mail
- Patient portal
- Secret shopping

When initiating a patient satisfaction survey, it is important to determine:

- What data measurements are required
- What data measurements are important to the organization's decision-making process
- What data measurements are important to day-to-day management

In the case of a customer satisfaction survey, the data relates to the customer perspective of their healthcare encounter.

The following are some sample customer satisfaction survey questions:

- Basic survey questions
  - How satisfied were you with your overall hospital stay?
  - How satisfied were you with your overall emergency room visit?
- Loyalty questions
  - How likely are you to choose our facility in the future?
  - How likely are you to recommend our facility to your friends?
- Product/Service questions
  - Did the staff respond to your concerns/complaints?
  - Did the staff address your emotional needs?
  - Did the staff work together to care for you?
  - Did the staff keep you informed?
  - Did the staff show concern for your privacy?
  - Was your wait time for tests and treatment acceptable?
  - Was the staff friendly and courteous?
  - Was the speed of admission acceptable?
  - Was the person who admitted you courteous?

Notice that the questions related to the service provided by individual caregivers emphasize compassion, concern and empathy more than clinical competence. Healthcare consumers are as interested in service and staff behaviors during their healthcare encounter as they are in clinical outcomes.

In addition to patient satisfaction surveys, healthcare facilities are also using internal surveys with employees and physicians to acquire feedback that is pertinent to the organization's operations. These surveys are designed to verify the level of employee engagement and loyalty, which provides the organization an opportunity to initiate programs to impact employee retention and customer service scores. Engaged employees provide better quality care and service.

These internal surveys deal not only with pay and benefits, but cultural issues such as teamwork, coworker relationships, employee relationships and view of senior leadership, available resources, training programs, recognition, work environment, job security, participation in decisions, and employee viewpoints of the organization's integrity and commitment to service.

HCAHPS (also known as Hospital CAHPS) stands for Hospital Consumer Assessment of Healthcare Providers and Systems and is a standardized survey of hospital patients that will capture patients' unique perspectives on hospital care for the purpose of providing the public with comparable information on hospital quality.

Purpose of Benchmark Processes

It is important to look at benchmarks for your processes and be measured against other institutions. It allows you to determine outcomes and where you can make improvements to reach those goals. It allows you to determine how you measure up against other institutions.

Once you determine how you measure up, you need to look to develop initiatives to improve those processes and improve your scores and outcomes.

Process and Quality Improvement Initiatives

Patient satisfaction surveys are only useful if the information collected is used for performance improvement. The purpose of any quality improvement program is to:

- Collect data
- Analyze data
- Initiate education or remedial action
- Evaluate actions

Organizations routinely share the results of surveys with departments that in turn evaluate the information and initiate a course of action to remedy identified problems.

Accrediting bodies such as The Joint Commission (TJC) and Centers for Medicare and Medicaid Services (CMS) require healthcare organizations to identify and report on quality improvement initiatives.

> TJC defines quality control as: the performance processes through which actual performance is measured and compared with goals, and the difference is acted on.
>
> TJC defines quality assurance/improvement as: an approach to the continuous study and improvement of providing healthcare services to meet the needs of individuals and others.
>
> TJC defines performance improvement as: the continuous study and adaptation of a healthcare organization's functions and processes to increase the probability of achieving desired outcomes.

In addition to the requirements placed on healthcare organizations to participate in specific clinical quality improvement initiatives, healthcare organizations continuously apply quality improvement principles to processes in all aspects of the facility, including Patient Access services.

For Patient Access departments, some customer service improvement plans should focus on proper telephone skills, greeting patients and keeping patients informed. Goals should be determined and usually driven by the tools used to measure customer service (e.g., Press Ganey, JD Power). With those goals in mind, an improvement program is developed, focusing on skills to improve the scores from the patient satisfaction surveys.

Quality and Customer Service KPIs

Key Performance Indicators, also known as KPIs, help an organization define and measure progress toward organizational goals. KPIs are quantifiable measurements, agreed to beforehand, that reflect the critical success factors of an organization or department. Whatever KPIs are selected, they must reflect the organization's goals, they must be key to its success, and they must be quantifiable (measurable).

The following KPIs are generally monitored in Patient Access:

- Pre-registration percentage
- Wait times: during scheduling and arrival
- Accuracy rate
- Upfront collections/point-of-service (POS) collections
- Unbilled dollars
- Productivity
- Patient satisfaction
- Employee satisfaction
- Insurance verification rate
- Scheduling abandonment rate

Communication

Communication is a giving or exchanging of information or messages by talk, gestures, writing, etc. We are expected to communicate effectively in everything we do. Effective communication includes more than just the ability to speak words in complete sentences. It includes some assessment to assure the message has been received. Only seven percent of a message is communicated by words, about 38 percent is tone of voice, and 55 percent is body language.

Patient Access staff members need to exhibit a high level of communication competency. When you are communicating the message, you need to obtain feedback from the patient so that you can clarify the message or validate the patient's response, demonstrating an understanding of the information.

How do we communicate?

- Talking
- Listening
- Hearing
- Understanding
- Body language
- Attitude
- Expression

Verbal communication is the initial form of communication. It is words or language. There are three steps to communication:

1. *Encoding:* The message is translated from an idea into symbols such as words, facial expressions, gestures and actions that "hopefully" represent the intended meaning. The more important the message, the more attention needs to be given to the encoding step.
2. *Transmission:* The encoded message is sent through some medium to the receiver. The communication channel through which the message is sent is often the determinate for success (face-to-face vs. letter).
3. *Decoding*: The receiver must translate or interpret the symbols used by the sender. The interpretation is based on what the symbols mean to the receiver.

Patient Access staff should communicate verbally in a pleasant and polite manner that the patient understands. The staff member should avoid using slang or medical jargon that the patient will not clearly understand.

In addition, when communicating with patients, it is important to be aware of paralanguage. Paralanguage is the tone, volume, pitch, quality and range of speech. This is the area where you have to account for differences in

communication: age, language, cultural differences, education levels and pronunciation.

Nonverbal communication clues are body language and visual behavior. Facial expressions, gestures and eye movements all play a role in patient communication. This type of communication is paramount in the interaction with the patient. By observing the nonverbal cues of the patient, you may be able to alter your communication style to ensure a successful exchange. Keep in mind that nonverbal communication plays an important role in how the staff member is perceived by the patient. Appropriate body language communicates a message of caring and compassion that is necessary to the success of the patient encounter. Positive body language includes firm handshakes, making eye contact, sitting up straight and paying attention.

Barriers to communication include:

- Language
- Misconception
- Pain
- Fear
- Cultural beliefs
- Religious beliefs
- Physical impairment
- Emotional impairment
- Stereotypes
- Bias, prejudice
- Age
- Educational background
- Low motivation to communicate
- Defensiveness
- Partisan point of view — occurs when staff hold personal points of view on an issue
- Gate-keeping — determining which information to share and which to withhold
- System overload — too many messages
- Bypassing — occurs when the sender and receiver don't have enough in common to accurately decode
- Distrust
- Status barrier — lower-level staff don't feel comfortable communicating with higher-level management

- Lack of assertiveness or self-confidence needed to voice opinions
- Impatience when trying to communicate with someone with less expertise

Barriers to communication can be both from the patient and your own personal beliefs. It is important to be sure your personal beliefs do not get in the way when communicating with patients.

Meeting the needs of a patient with specific communication barriers takes diplomacy, tact and patience. For hearing impaired patients, interpreter services may be required. If the hearing deficit does not require an interpreter, the Patient Access staff member can speak while facing the patient, lower the pitch of their voice, use notepads and demonstrate needs.

Visually impaired patients should be told what is going to happen at each step of the exchange. This patient will need to be escorted to ensure safety. Verbally explaining the physical environment is key to assisting the visually impaired patient to gain comfort. This would also include noises in the area that may cause concern or interest to the patient.

If a patient demonstrates speech impairment, allowing time to gather thoughts and express themselves verbally is important. Allowing the patient additional time is important to show a level of caring and compassion.

Mentally impaired patients may have difficulty orienting to reality and will need simple-to-understand instructions and sentences. The staff member will need to ask questions designed to keep the patient focused in order to gain the necessary response.

Language differences can also pose unique problems. As with all barriers to communication, the use of an interpreter service or assistance of another, specially trained hospital staff member may be required. Avoid using family members as interpreters. Use a phone interpreter service if necessary.

Effective Listening Techniques

- Use facilitation techniques such as “please, tell me more about your concern”
- Listen actively — keep your mind on what the speaker is saying
- Assume something important is being said — motivation to listen is in direct proportion to the expectation of importance
- Be responsive to the speaker — being responsive to comments by nodding or making eye contact makes it easier to pay attention
- Stay tuned to the speaker — pay attention when content may get difficult so as not to get “lost”

- Stay in the moment and do not begin to formulate what you will say until the patient has finished speaking
- Repeat back the patient's question or concern
- Paraphrase the patient's remarks in your own words
- Ask questions
- Be patient

Apply HEAT

- H: Hear them out
- E: Empathize with the customer
- A: Apologize for the inconvenience
- T: Take responsibility for action

If you are having trouble connecting or positively communicating, try these patient communication techniques:

- Ask open-ended questions, questions that require patients to make their own response — not just *yes* or *no*, but detailed information
- Reflecting: Ask the patient to repeat what they have heard to ensure understanding
- Paraphrasing: Restate what you heard in your own words; this demonstrates understanding and verifies accuracy
- Using examples: Helps to clarify information; using visual examples can help with specific situations
- Summarizing: Briefly review the information; allow the patient to clarify and correct
- Allow for silences: We think in the silences — it gives the patient time to think and respond. Be careful of prolonged silences. You can move the interview along with additional open-ended questions — think before you speak, but don't think too long.

Patient Safety Guidelines

Permanent Identification of the Patient

The most important task undertaken by Patient Access is proper patient identification. Patient identification includes obtaining the patient's legal name, date of birth and additional identifying information. This information is matched against the existing Master Patient Index (MPI) to retrieve the patient's permanent medical record if

there has been a previous encounter with the healthcare system. If the patient is new to the healthcare system, the basic identifying information becomes the basis of a new health record.

Basic identifying information is used throughout the healthcare encounter to ensure patient safety. The Joint Commission establishes National Patient Safety Goals. Healthcare organizations that are accredited by The Joint Commission must comply with these patient safety goals. Goal #1 is improving patient identification, which improves patient safety. All healthcare workers must use a minimum of two identifiers when providing care, treatment and services. Patient Access is charged with verifying the patient identifiers and educating the patient on this important safety initiative.

In addition to obtaining accurate information to identify the patient, Patient Access should follow their facility-specific guidelines to secure the patient's demographic and financial information. Patient Access is privy to confidential information that needs to be protected. This is especially important as cases of identity theft and insurance fraud increase.

Standard Precautions

According to the Centers for Disease Control and Prevention (CDC), Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. Standard Precautions are a set of infection control practices that healthcare personnel use to reduce transmission of microorganisms in healthcare settings.

Standard Precautions protect both healthcare personnel and patients from contact with infectious agents. Standard Precautions include: hand hygiene (hand washing with soap and water or use of an alcohol-based hand sanitizer) before and after patient contact and personal protective equipment (PPE) when exposure to blood, body fluids, excretions, secretions, mucous membranes or non-intact skin is anticipated.

Hand Hygiene

Hand hygiene is part of Standard Precautions. It can reduce the transmission of healthcare-associated infections.

The preferred method of hand decontamination is with an alcohol-based hand rub, if hands are not visibly soiled. If hands are visibly soiled, an alcohol-based hand rub may be utilized after removing visible material with soap and water. Alcohol-based hand rubs are a convenient option for hand hygiene because:

- They kill more effectively and more quickly than hand washing with soap and water
- They are less damaging to skin than soap and water, resulting in less dryness and irritation

- They require less time than hand washing with soap and water
- Bottles/dispensers can be placed at the point of care so they are more accessible

Personal Protective Equipment (PPE)

Personal protective equipment, or PPE, as defined by the Occupational Safety and Health Administration (OSHA), is “specialized clothing or equipment, worn by an employee for protection against infectious materials.”

OSHA issues regulations for workplace health and safety. These regulations require use of PPE in healthcare settings to protect healthcare personnel from exposure. Healthcare facilities must provide their employees with appropriate PPE. The CDC issues recommendations for when and what PPE should be used to prevent exposure to infectious diseases. PPE, specifically gloves, should be located in or be available to Patient Access.

Patient Access employees need to be aware of the various regulations and guidelines regarding Standard Precautions, infection control and PPE utilization to ensure compliance with the standards. The CDC establishes recommendations; **it is up to each facility to develop and implement infection control practices.**

The CDC added a condition to the practice recommendations for Standard Precautions: Respiratory Hygiene/Cough Etiquette. While Standard Precautions generally apply to the recommended practices of healthcare personnel during patient care, Respiratory Hygiene/Cough Etiquette applies broadly to all persons who enter a healthcare setting, including healthcare personnel, patients and visitors. The CDC’s recommendations evolved from observations during the SARS epidemic that failure to implement basic control measures with patients, visitors and healthcare personnel with signs and symptoms of respiratory tract infection may have contributed to SARS transmission.

Patient Access employees should be familiar with the policies at their facility regarding Emergency Medical Treatment and Labor Act (EMTALA) and other considerations that impact the process regarding patient transfers.

Customer Experience Practice Questions

See page 142 for answer key

1. Under Title III of the Americans with Disabilities Act, hospitals are required to:
   - **a.** Provide information as to where restrooms are located.
   - **b.** Provide patients and families all documentation for the admission.
   - **c.** Provide resources to eliminate barriers in communication.
   - **d.** Ensure all patients are accommodated for admission.

2. What is **not** important when initiating a patient satisfaction survey?
   - **a.** What data measurements are required
   - **b.** What data measures are important to day-to-day management
   - **c.** What data measures are important to the organization's decision-making process
   - **d.** What data measures are needed to care for the patient

3. Which is not a purpose of any quality improvement program?
   - **a.** Collect data
   - **b.** Analyze data
   - **c.** Blame someone for the mistake
   - **d.** Evaluate actions

4. Which of the following is not a patient satisfaction survey:
   - **a.** CMS survey
   - **b.** JD Power
   - **c.** Press Ganey
   - **d.** Post-service telephone call to patient

5. Communication is:
   - **a.** Providing a newspaper to the patient or family
   - **b.** Exchanging information with the patient
   - **c.** Sharing the telephone with the patient
   - **d.** Giving a patient a prescription

6. Which is not a KPI in Patient Access?
   - **a.** Accuracy rate
   - **b.** CLABSI rate
   - **c.** Patient satisfaction score
   - **d.** Pre-registration rate

7. HEAT stands for:
   - **a.** Help the patient, explain the situation, apologize, thank the patient
   - **b.** Hear the patient out, explain the situation, apologize, take responsibility for actions
   - **c.** Hear them out, empathize with the customer, apologize, take responsibility for actions
   - **d.** Hear them out, empathize with the customer, amend the situation, thank the patient

8. All of the following are ways we communicate, except:
   - **a.** Body language
   - **b.** Eating
   - **c.** Talking
   - **d.** Facial expressions

9. What are the three steps to communication?
   - **a.** Decipher, transmission, receiving
   - **b.** Encoding, transmission, sharing
   - **c.** Encoding, transmission, decoding
   - **d.** Decipher, receiving, transmitting

10. Compassion and respect can be demonstrated in all of the following ways, except:
    - **a.** Smiling
    - **b.** Making eye contact
    - **c.** Calling the patient “Dear”
    - **d.** Greeting the patient

REGULATORY COMPLIANCE

Chapter Objectives

In this chapter, the student will learn to:

- Recognize requirements of OIG (e.g., EMTALA, patient's rights and responsibilities, advance directives)
- Recognize requirements for CMS (e.g., HIPAA, IMM, MSP, ABN, Condition Code 44, fraud and abuse)
- Comprehend accreditation guidelines (e.g., TJC, DNV-GL)
- Recognize requirements for other government agencies (e.g., TRICARE, VA, Medicaid)

Key Terms

- Accreditation
- Advance beneficiary notice (ABN)
- Advance directive
- Anti-Kickback Statute
- Centers for Medicare and Medicaid Services (CMS)
- Condition code 44
- CHAMPVA
- DNV-GL Accreditation
- Electronic health record (EHR)
- Electronic protected health information (ePHI)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Fair Debt Collection Practices Act (FDCPA)
- False Claims Act
- Healthcare Facilities Accreditation Program (HFAP)
- Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- HITECH Omnibus of 2013
- Important Message from Medicare (IMM)
- The Joint Commission (TJC)
- Living will
- Meaningful Use (MU)
- Medicaid
- Medically necessary
- Medicare Administrative Contractor (MAC)
- Medicare Outpatient Observation Notice (MOON)
- Medicare Savings Programs
- Medicare Secondary Payer (MSP) questionnaire
- Minimum necessary standard
- Modified Adjusted Gross Income (MAGI)

- The Patient Protection and Affordable Care Act of 2010 (PPACA)
- Power of attorney
- Personally identifiable information (PII)
- Protected health information (PHI)
- Presumptive Eligibility
- Restricted Disclosure
- The Stark Law
- Telephone Consumer Protection Act (TCPA)
- TRICARE
- Two-Midnight Rule
- Unbundling
- Upcoding
- Veterans Administration (VA)
- Veterans Choice Program

The Office of the Inspector General (OIG)

The **Office of the Inspector General (OIG)** is a division of the US Department of Health and Human Services (HHS). It is the OIG's responsibility to protect the integrity of HHS programs and the well-being of beneficiaries by detecting and preventing fraud, waste and abuse; improve program efficiency and effectiveness; and holding accountable those who do not meet program requirements or violate the federal healthcare law. The two major programs under HHS are Medicare and Medicaid.

The OIG is also responsible for educating the public about fraudulent schemes so they can protect themselves and know how to report suspicious activities. Some of the more common fraud laws include: The Stark Law, the Anti-Kickback Statute and the False Claims Act.

OIG and Compliance

The OIG states that "compliance is a dynamic process that helps to ensure that hospitals and other healthcare providers are better able to fulfill their commitment to ethical behavior, as well as meet the changes and challenges being imposed upon them by Congress and private insurers." With the establishment of a voluntary compliance program and a designated hospital compliance officer, hospitals will be able improve the quality of patient care, substantially reduce fraud, waste and abuse, and reduce the cost of healthcare to federal, state and private health insurers.

Elements of a Compliance Program include:

I. **Establish compliance standards, procedures and policies**

II. **Assign oversight responsibility for compliance to an individual high in the organization's structure (i.e., dedicated compliance officer and a compliance committee)**

III. **Screening and evaluation of employees, physicians, vendors**

IV. **Communication, education and training on compliance issues**

V. **Monitoring, auditing and the establishment of internal reporting systems (e.g., anonymous hotlines, email, etc.)**

VI. **Discipline for non-compliance**

VII. **Respond appropriately and immediately to detected offenses**

Components of the establishment of compliance standards, procedures and policies that have an impact on Patient Access services might include:

- Code of conduct
- Admission policy
- Discharge policy
- Patient referrals
- Physician agreements
- Claim development

Special areas at high risk for non-compliance

- Billing for items or services not rendered
- Providing medically unnecessary services
- Upcoding
- Outpatient services rendered in connection with inpatient stays
- Duplicate billing
- Unbundling
- Patients' freedom of choice
- Credit balances

Patient's Rights and Responsibilities

There are several laws detailing what needs to be followed to protect patients. As a Patient Access representative, it is important to know these laws and how they affect you, your healthcare organization and your

patients. Patients also have other rights and desires concerning their care and can communicate these needs in several ways, such as advance directives, which can affect their care.

The Patient Protection and Affordable Care Act (PPACA)

Often shortened to the **Affordable Care Act (ACA)** and nicknamed "Obamacare," the PPACA is a US federal statute signed into law in 2010 by President Obama. It is currently administered under the HHS. Its purpose is to reform healthcare in the U.S. and includes reforms to affordability, quality and availability. Some of the provisions of the law include:

- Ensure access to health insurance and protect against unaffordable out-of-pocket costs
  - Tax credits established for low-income Americans
- Eliminating lifetime limits on benefits
- Provide assistance for those with pre-existing conditions
- Extend dependent coverage up to age 26
- Expand Medicaid coverage to more low-income Americans
- Reduce the prescription drug coverage gap ("donut hole") for those receiving the Medicare Part D Prescription Drug Benefit. A whole title of the law focuses on Medicare reform.
- Require coverage of preventative services and immunizations
- Establish internet portals to assist with the identification of coverage options (e.g., The Exchange)

The main goal of PPACA was to increase the amount of Americans who have access to affordable healthcare. It accomplished this by expanding Medicaid coverage, providing tax credits to both small employers and individuals who need help paying for insurance, and providing online health insurance exchanges, or marketplaces, where individuals can buy insurance and receive cost-assistance through income-based tax credits. Most marketplace plans had several different options available — Platinum, Gold, Silver and Bronze — so that individuals could choose a plan that most served their needs.

Emergency Medical Treatment and Labor Act (EMTALA)

Emergency Medical Treatment and Labor Act (EMTALA) is a federal law enacted in 1986 by the Centers for Medicare and Medicaid Services (CMS) to protect patients against discrimination, regardless of an individual's ability to pay. EMTALA mandates that a patient receives a medical screening exam (MSE) and stabilizing treatment when seeking emergency medical care or is in active labor. EMTALA is also known as the "Anti-Dumping" Statute. At the time the law was enacted, hospitals were allowed to refuse treatment to anyone. Many

hospitals believed that indigent patients should receive care through charitable organizations or through uncompensated care hospitals and would transfer patients without adequate screenings or stabilization, resulting in lost lives, suffering and additional medical care. EMTALA was put in place to ensure that all emergency patients receive care, regardless of their socioeconomic status.

Organizations may interpret EMTALA law differently. While some allow the registrar to ask the patient for an insurance card and copy it prior to a patient receiving an MSE, others may determine that registration must wait until after the MSE is complete. Regardless, a medical screening exam or stabilizing treatment must not be delayed in order to inquire about insurance or payment status. Coverage or payments cannot be discussed until the patient has been triaged and stabilized. Payment cannot be accepted prior to treatment, even if the patient or family volunteers.

EMTALA surveys are complaint-driven; state agency surveyors acting for CMS only conduct an EMTALA investigation in response to a complaint about emergency services care.

EMTALA VIOLATIONS

A hospital that negligently violates the statute may be subject to a civil money penalty (i.e., a fine, but without criminal implications) of up to $50,000 per violation. If the hospital has fewer than 100 beds, the maximum penalty is $25,000 per violation. Also, a hospital found to be in violation may have its provider agreement with CMS revoked, which means they can no longer bill for Medicare, Medicaid or military services.

Fair Debt Collection Practices Act (FDCPA)

The Fair Debt Collection Practices Act (FDCPA) protects consumers by prohibiting debt collectors from using unfair, abusive or deceptive practices while attempting to collect from a consumer. This law, enforced by the Federal Trade Commission (FTC), restricts how and when collection attempts and contact can be made with the consumer. Since healthcare organizations collect payment, under the law they are considered a debt collector and must follow the FDCPA provisions. A few of the things debt collectors are required to do include identifying themselves and notifying the consumer that the communication is an attempt to collect a debt in every conversation; advising that any information collected will be used to aid in the collection of the debt; and notifying the consumer of their right to dispute the debt in full or in part, with the creditor.

Telephone Consumer Protection Act (TCPA)

The Telephone Consumer Protection Act of 1991 (TCPA) was created to regulate the use of prerecorded messages and auto-dialers. This act safeguards consumer privacy by restricting unwanted telemarketing communications, which has expanded to include text-based telemarketing. Healthcare organizations that use a telephone to contact patients legally fall under this law and must follow it. Under this act, TCPA companies are required to maintain and honor the National Do Not Call (DNC) Registry and a company-specific DNC list. Additionally, companies cannot call residences prior to 8 am, or after 9 pm, without previous consumer consent, and must provide their name, the company they are calling for, and a means to contact them if requested.

Advance Directives

An **advance directive**, also known as a **medical directive**, **healthcare directive** or a **living will**, is a legal document in which a person has outlined what they would like to be done if they are no longer able to make decisions for themselves due to incapacity or illness. There is also a more specific type of living will called a durable **power of attorney**, which is a document that authorizes a specific person to make decisions on their behalf when they have become incapacitated. Many healthcare organizations will ask if a person has an advance directive on file, and many organizations either offer a blank form to fill out or have a form available for download from their website for patients to use to complete an advance directive.

Centers for Medicare and Medicaid Services (CMS)

The **Centers for Medicare and Medicaid Services (CMS)**, a federal agency under the Department of Health and Humans Services (HHS), administers Medicare and partners with state governments for administration of Medicaid and other programs, including the Children's Health Insurance Program (CHIP). Additionally, CMS was tasked with administration simplification standards under HIPAA, and oversees quality standards in long-term care facilities, or nursing homes, as well as maintains oversight of the HealthCare.gov website. As part of its Medicare administration, CMS has several rules of particular importance to Patient Access professionals concerning registration, Meaningful Use, payers, medical necessity, fraud and abuse.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** originally focused on regulations related to health insurance portability. Portability in HIPAA means that once a person has insurance coverage, when they change health plans (most commonly when changing jobs), the previous coverage may be used to reduce or eliminate any pre-existing condition exclusions that might apply under the new plan. This regulation has branched out to cover multiple other areas of healthcare coverage in an attempt to reduce the cost and administrative burden of providing healthcare and the protection of electronic and financial records. The HIPAA

regulations come under the jurisdiction of the HHS. The Office of Civil Rights (OCR) is responsible for enforcement of the regulations.

The Administrative Simplification (AS) provisions of HIPAA are intended to reduce costs and administrative burdens of healthcare through the standardization of electronic administrative and financial transactions. Any **protected health information (PHI)** that is collected, stored or transmitted electronically must be protected.

Administrative Simplification provisions include:

- Standards for Privacy
- National Provider Identification (NPI)
- Transaction and Code Sets
- Employer Identification (EID)
- Security and Electronic Signature Standards

HIPAA PRIVACY RULE BASICS

- Major goal is to assure that individuals' health information is properly protected
- Creation of a national set of standards for the use and disclosure of an individual's protected health information (PHI)
- Individual's rights to understand and control how their health information is being used
- Rules apply to health plans, healthcare clearinghouses and all healthcare providers who hold individual identifiable health information or transmit information electronically
  - Use and disclosure of PHI is permitted without the individual's permission for Treatment, Payment and Healthcare Operations (TPO)
  - Limited information can be released for purposes of research and/or public health
  - Opportunity to agree or object — asking the individual for permission outright; examples of this would be asking the patient if they wish to have their name placed in the facility directory or permission to disclose to individuals' families and friends
  - Required by law (court orders, regulations)
  - Victims of abuse, neglect or domestic violence
  - Public health activities such as the collection of information for controlling diseases, child abuse and neglect reports, exposure to a communicable disease, OSHA, FDA recalls, etc.

Minimum Necessary Standard

The **minimum necessary standard** means that people should only access, use or disclose the health information that is minimally necessary to accomplish a given task or purpose. For instance, to register a patient, a Patient Access professional would need to access demographic information like name, address and phone number, but would not need to look through a patient's medical chart. Basically, an employee should only be granted access to PHI in order to carry out their duties in their current role. A Patient Access professional should have access to and use the patient information provided in their chart or registration as assigned. **Opening up a patient's information out of curiosity is a HIPAA violation!** Willfully sharing that information with others who are not authorized to have the information is a serious HIPAA violation.

What type of information is considered to be PHI? It includes anything that can be considered **personally identifiable information (PII)**, such as:

- Patient names
- Address
- Social Security number
- Driver's license numbers
- Medical record numbers
- Account or encounter numbers
- Date of birth
- Phone numbers
- Insurance policy/ID numbers
- Names of relatives
- Computer IP addresses
- Email addresses
- Biometric identifiers, including finger and voice prints
- Full-face photographic images

Electronic Protected Health Information (ePHI)

The sensitive health information maintained by healthcare providers and health plans have become an increasingly attractive target for cyberattacks. **Electronic protected health information (ePHI)** requires strong

data security safeguards. The National Institute of Standards and Technology (NIST) has provided organizations with detailed security guidance to help understand, communicate and manage cybersecurity risks, such as cloud computing, to help protect ePHI. One recommended standard is to deploy encryption on laptops, tablets and removable storage devices.

HIPAA VIOLATIONS

A HIPAA breach is the use of or disclosure that compromises the security or privacy of a patient's protected health information (PHI). Following a breach, notification must be provided to the affected individuals. If the breach is over 500 individuals, notice to the media must be provided and a notice to the Secretary of HHS.

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)

The Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) was created to stimulate the adoption of electronic health records (EHR). Financial incentives were offered to healthcare providers for demonstrating meaningful use of EHR. HITECH added data breach notification rules and increased penalties and fines to ensure that any EHR technology created under HITECH does not compromise the HIPAA security and privacy laws.

The HITECH Omnibus Update of 2013

This update to the HITECH Act revised provisions that focused on an individual's right to request restrictions on the disclosure of PHI and on an individual's right to access his or her PHI.

The first right to restrict PHI disclosure, the "**Restricted Disclosure" or "HITECH Omnibus**," is important because a patient can request that a healthcare organization not disclose medical information to the patient's insurance company. This is important, and action must be completed in a timely manner and the correct information must be noted in the registration system for this to occur properly. Failure to note a patient's wishes properly, or follow policy, can have extremely negative consequences for both the patient and the healthcare organization. For a healthcare organization to restrict disclosing information about a service, the patient must pay for the service in full out of pocket at the time of service. The restriction does not apply to follow-up visits if they are not paid in for in full out of pocket.

The second right allows a patient to access his or her PHI stored in an EHR. The act states that the individual has the right to a copy of their PHI in electronic format, or a hard copy if the file format requested is not readily

available, in a timely manner, normally 30 days. The individual cannot be charged more than a reasonable labor cost for copying the PHI and may not be charged a retrieval fee for locating the data.

HOW CAN A PATIENT ACCESS PROFESSIONAL PROTECT A PATIENT'S PHI?

- Interview the patient in private whenever possible
- Never discuss patient information in public
- Lock your computer when you step away from your desk
- Be sure all mobile devices are secure
- Have computer screens facing away from public view
- Never throw items containing PHI in the trash; use reciprocals dedicated to secure shredding/recycling
- Never share your passwords with anyone
- Never let someone use your computer while you are signed on
- Never look up a patient's information because you can, only when your role dictates the use of patient information

Payment Card Industry Data Security Standard (PCI DSS)

While HIPAA deals with specifically healthcare related PHI, the PCI standards specifically deal with protecting credit card personally identifiable information (PII). It is required for any Patient Access professional who handles point-of-service payment collections to follow PCI standards. Any organization that handles branded credit cards, such as Visa, MasterCard, American Express and Discover, is responsible for maintaining the security of all cardholder data. Similar to PHI, cardholder data is any information that could identify your patient or their bank account. This is not a provision of HIPAA, but instead a program created by the credit card industry in an effort to reduce credit card fraud and abuse. Some of the ways that Patient Access professionals can protect cardholder information include:

- Never copy a patient's credit card
- Obtain and enter the credit card information in a private place
- Only use encrypted devices
- Never write down card holder data
- Remove all receipts from the printer promptly

Medicare

Medicare provided health insurance for over 55 million people in 2015, approximately 46 million were aged 65 or older[1]. Medicare provides healthcare for those over 65, as well as younger people with disabilities. As part of the administration simplification and fraud reduction efforts, there are several topics of interest to Patient Access professionals, including Meaningful Use, inpatient and outpatient rules, the MSP questionnaire, medical necessity and ABNs.

Meaningful Use (MU)

Meaning Use (MU) is an incentive program established as part of the HITECH Act to provide monetary incentives for the adoption and meaningful use of health information technology and qualified electronic health records (EHR). Meaningful Use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for CMS Incentive Programs.

MU gives patients access to their electronic health information, orders and discharge instructions, and allows them to view and maintain an up-to-date problem list with current and active diagnosis, allergy and medication lists, immunization records, lab results and advance directives information. The goal of providing MU technology is to:

- Improve quality, safety and efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination and population and public health
- Maintain privacy and security of patient health information

Two-Midnight Rule

CMS states that for inpatient stays to be reimbursable under Medicare Part A, the stay must cross two midnights. Any stays less than the two midnights are reimbursed under Medicare Part B as an outpatient. There are some rare exceptions to this rule on a case-by-case basis, based on the judgement of the admitting physician and supporting documentation in the medical record.

[1] 2016 Annual Report of the Medicare Trustees (for the year 2015), June 22, 2016

Condition Code 44

Sometimes a Medicare patient is admitted to a hospital as an inpatient but, upon internal review, the hospital determines the services did not meet inpatient criteria and the admission is changed to observation (OBS). This rule has become informally known as "condition code 44." CMS uses this code to track and monitor these occurrences.

The change from Inpatient to OBS is permissible, but only if all of the following conditions are met:

- The change in patient status from inpatient to outpatient (observation) is made prior to discharge or release while the member is still a patient of the hospital;
- The hospital has not submitted a claim for inpatient admission;
- A physician concurs with the utilization review committee's decision;
- The physician and utilization review committee's decision is documented in the patient's medical record; and
- The medical record should contain orders and notes that indicate why the change was made and that the care was furnished to the member and the participants making this decision, in order to change the status.

Important Message from Medicare (IMM)

IMM is a form given to all Medicare beneficiaries who are inpatients in participating hospitals. It explains:

- Rights as hospital patients, including the right to all the hospital care needed and follow-up care after discharge
- Advises beneficiaries about what to do if they feel they are being discharged early and provides the phone number for the PRO (Peer Review Organization). Beneficiaries may remain in the hospital without being charged while the case is being reviewed. Hospitals cannot force beneficiaries to leave while their case is being reviewed.

Medicare Outpatient Observation Notice (MOON)

The MOON is a form given to Medicare beneficiaries to inform them of their outpatient observation status and to explain to them what that may mean financially. The MOON informs patients that they may have:

- A co-payment
- 20% co-insurance for services after their yearly deductible
- Their coverage and payment for aftercare may be affected (skilled nursing home, Medicaid, MA and

medications)

Medicare as Secondary Payer (MSP)

For Medicare programs to work effectively, providers have a significant responsibility for the collection of patient information. Medicare requires that we ask the patient pertinent questions to determine if there are any other payers or situations that may pay primary to Medicare and that we bill based on the answers to these questions. Failure to comply is considered a violation of the provider agreement and could result in audits and fines. The questionnaire provided by Medicare is called the Medicare Secondary Payer (MSP) questionnaire.

An MSP questionnaire must be completed by the patient or their designated Power of Attorney (POA) or legal representative on all Medicare Original patients each time a service is provided. Since the answers to these questions can change from visit to visit, Medicare mandates that the questions be asked each time. Never assume the answers nor copy them from a previous case — the questions must be asked each and every time.

Retirement Dates: Medicare requires that a beneficiary's retirement dates be recorded in the MSP. This question is used to help determine coverage with group health plans. If the beneficiary is unable to remember their retirement dates, Medicare offers the following guidelines:

1. If the beneficiary retired prior to the Medicare A entitlement date on their card, use the entitlement date.
2. If the beneficiary is dependent under their spouse's group health plan and the spouse retired prior to the beneficiary's Medicare A entitlement date, use the patient's Medicare entitlement date.
3. If the beneficiary worked beyond their Medicare A entitlement date and it has been at least five years since they retired, enter the date of service five years ago.
4. If the retirement date occurred less than five years ago, the hospital must obtain the retirement dates from other resources.

Recurring Visits: Per CMS regulations, for recurring visits (where one account is created and the patient has several recurring visits for the same service, such as physical therapy, all charges for each visit are entered into the one account), you are required to verify the patient's MSP information every 90 days to ensure the information is current and updated as needed.

Take a look at Table 1 below, which lists some common situations where a beneficiary has both Medicare and other health plan coverage and lists which entity pays first and second. Image courtesy of CMS.gov.

Table 1. Analysis of Common MSP Coverage Situations

Individual	Condition	Pays First	Pays Second
Is age 65 or older, and covered by a Group Health Plan (GHP) through current employment or spouse's current employment	The individual is entitled to Medicare The employer has less than 20 employees	 Medicare	 GHP
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The individual is entitled to Medicare The employer has 20 or more employees, or the employer is part of a multi-employer group with at least one employer employing 20 or more individuals	 GHP	 Medicare
Is age 65 or older, has an employer retirement GHP, and is not working	The individual is entitled to Medicare	 Medicare	 Retiree Coverage
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has less than 100 employees	 Medicare	 GHP
Is under age 65, disabled, and covered by a GHP through his or her current employment or through a family member's current employment	The individual is entitled to Medicare The employer has 100 or more employees, or the employer is part of a multi-employer group with at least one employer employing 100 or more individuals	 GHP	 Medicare

Individual	Condition	Pays First	Pays Second
Has End-Stage Renal Disease (ESRD) and GHP coverage was the primary plan prior to the individual becoming eligible and entitled to Medicare based on ESRD	First 30 months of Medicare eligibility or entitlement	 GHP	 Medicare
Has ESRD and GHP coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 GHP
Has ESRD and Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage prior to becoming eligible or entitled to Medicare	First 30 months of Medicare eligibility or entitlement	 COBRA	 Medicare
Has ESRD and COBRA coverage	After 30 months of Medicare eligibility or entitlement	 Medicare	 COBRA
Is covered under Workers' Compensation (WC) because of a job-related illness or injury	The individual is entitled to Medicare	WC for health care items or services related to job-related illness or injury  Workers' Compensation * See section titled, "When May Medicare Make a Conditional Payment?"	 Medicare

Medical Necessity

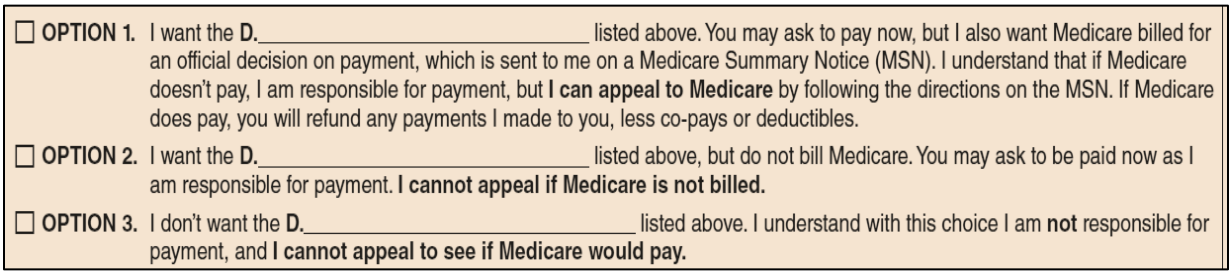
Medicare normally covers services deemed "medically necessary." According to Medicare.gov, "**medically necessary**" is defined as "healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine." Medicare will not make payment for expenses that they feel are not reasonable and necessary for the diagnosis provided by a physician. Patient Access professionals often run a medical necessity check using software that accesses the Medicare Medical Necessity Database. Determinations are made at both the national level (NCD) and the local level (LCD). If the service is determined to not meet the Medicare standards, an ABN (Advance Beneficiary Notice) form is presented to the patient. This form, similar to a financial waiver, informs the patient of the possible non-coverage and the selection.

Advance Beneficiary Notice (ABN)

The **Advance Beneficiary Notice (ABN)** is a written notice that must be issued to a Fee-For-Service (Original Medicare) beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity. The ABN allows the beneficiary to make an informed decision as to whether or not they wish to receive the item or service and accept financial responsibility if Medicare does not pay. If written notice is not provided and Medicare denies the service because the service doesn't meet their medical necessity guidelines, the patient cannot be billed or held financially liable, and the hospital must write off the amount of the service.

An ABN form must list the items or services that Medicare isn't expected to pay for and the explanation as to why. It must also give an estimated cost of these services.

The ABN form has three options. The patient must read and select one of the options:



☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to pay now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

CMS Fraud and Abuse

According to Medicare, $60 billion was lost to fraud, waste, abuse and improper payments in 2015. This kind of waste results in higher healthcare costs and taxes for everyone. Fraud is the intentional deception or

misrepresentation, and abuse is when healthcare providers unintentionally bill incorrectly, causing unnecessary costs.

CMS has a Fraud and Abuse program in place to combat fraud and abuse. This program helps to guarantee security for the Medicare, Medicaid and Child Health programs. CMS works with the Department of Justice (DOJ), the Office of the Inspector General (OIG) and other federal, state and local agencies to take action against those who commit fraud and abuse. Medicare contractors screen claims routinely and are required to have fraud investigators on their staff. **It is crucial that Patient Access professionals understand what CMS considers fraud and abuse to help mitigate any potential violations**. Examples of fraud and abuse include:

- Billing for services not rendered
- Billing for services multiple times
- Knowingly billing for services at a higher complexity
- Billing for unnecessary medical services
- Misusing codes on a claim, such as upcoding or unbundling
- Referring to an entity in which the physician has an ownership or investment

The **Anti-Kickback Statute**, a federal criminal statute, prohibits the exchange, or offer to exchange, anything of value, while trying to get federal healthcare program business referrals or the generation of business. This could include cash, free rent, expensive hotel stays and other incentives in exchange for business referrals.

The **Stark Law** is actually a group of several federal laws that prohibit physician self-referral. This means that a physician cannot refer a Medicare or Medicaid patient to a place providing designated health services (DHS) in which the physician, or a physician's immediate family member, has any financial relationship, unless an exception applies.

The **False Claims Act** targets fraud against the government and targets persons and companies who defraud government programs. The *qui tam* provision, or the "whistleblower's" provision, allows non-government individuals to "blow the whistle" on fraud against the government. In return, persons who turned in fraud in good faith may receive up to 30 percent of any recovered damages[2].

[2] Justice Department Recovers Over $3.5 Billion From False Claims Act Cases in Fiscal Year 2015, https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015.

IN THE END, UPCODING DOESN'T PAY: HEALTHCARE PROVIDER PAYS $60 MILLION TO SETTLE FALSE CLAIMS ACT ALLEGATIONS

False Claims Act allegations are no trivial matter. When TeamHealth Holdings bought out IPC Healthcare, it turns out that they became legally responsible for IPC's past actions. IPC was charged with upcoding services in a systematic manner and encouraging false billings by its medical professionals in order to bill for a higher level of service than was provided. The new owners have entered into a five-year Corporate Integrity Agreement (CIA) with the HHS-OIG to increase accountability and transparency and to detect future fraud and abuse promptly. Additionally, the healthcare organization agreed to pay $60 million, plus interest.

The lawsuit was filed by Dr. Bijan Oughatiyan, a physician formerly employed by IPC. Under the *qui tam*, or whistleblower, provision of the False Claims Act, not only could Dr. Oughatiyan turn in IPC for defrauding the government, but he will also be rewarded handsomely for his integrity, with an approximate $11.4 million award.

Accrediting Organizations and Accrediting Guidelines

Accreditation is a review process conducted by an independent third party that an organization participates in to show their ability to meet or exceed established industry standards and regulatory requirements. In healthcare, accreditation reflects an organization's dedication to patient care, high standards and an extraordinary patient experience. There are several accrediting bodies in healthcare, including The Joint Commission (TJC), Healthcare Facilities Accreditation Program (HFAP) and DNV-GL.

WHY SEEK ACCREDITATION?

- Helps organize and strengthen patient safety efforts
- Enhances community confidence in the quality and safety of care and services
- Improves risk management and risk reduction
- May reduce liability insurance costs
- Provides education to improve business operations
- Provides professional advice, counsel and enhances staff education
- Provides authority for Medicare certification
- Recognized by insurers and other third parties
- Aligns healthcare organizations with one of the most respected names in healthcare

The Joint Commission (TJC)

The Joint Commission (TJC) is an independent, not-for-profit organization that evaluates and accredits more than 21,000 healthcare organizations in the United States[3]. TJC evaluates hospitals, healthcare networks, managed care organizations and healthcare organizations that provide home care, long-term care, behavioral health care, and laboratory and ambulatory care services. TJC was founded in 1951 and is considered the nation's oldest and largest standards-setting and healthcare accrediting body. Its mission is "to continuously improve healthcare for the public, in collaboration with other stakeholders, by evaluating healthcare organizations and inspiring them to excel in providing safe and effective care of the highest quality and value."

The Joint Commission focuses on safety and quality care. It addresses items such as patient rights, infection control, medication management, staff competencies, data collection and the prevention of medical errors. TJC evaluates an organization to identify strengths and weaknesses and provides policy leadership and oversight. Accreditation is usually a three-year cycle. It often conducts random, mid-cycle surveys to highlight possible problem areas that may need to be resolved.

Healthcare Facilities Accreditation Program (HFAP)

The **Healthcare Facilities Accreditation Program (HFAP)** is authorized by CMS to survey all hospitals for compliance with the Medicare Conditions of Participation and Coverage. Because it is considered the deeming authority by CMS, its accreditation requirements are clearly tied to Medicare's guidelines.

DNV-GL Accreditation

DNV Healthcare is another accreditation organization approved by CMS in 2008. It has accredited approximately 500 hospitals. It integrates the CMS Conditions of Participation with the IDO 9001 Quality Management program. Its survey teams visit annually. It offers several certifications, such as Managing Infection Risk and Primary Stroke Center. Its tagline is "Safer, Smarter, Greener."

Regulatory Compliance Guidelines for Government Agencies & Insurances

There are several main programs with which Patient Access professionals should be familiar, including Medicaid, TRICARE, CHAMPVA, VA and Veterans Choice. This section discusses these programs and highlights some of the regulatory features of these programs.

[3] The Joint Commission, http://www.jointcommission.org.

Medicaid

Medicaid is a joint federal and state program that provides health coverage to over 72.5 million Americans.[4] Medicaid covers low-income adults, children, pregnant women, elderly adults and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.

Federal law requires that states cover certain groups of individuals to participate in Medicaid. Some of the mandatory eligibility groups include:

- Low-income families
- Transitional medical assistance
- Qualified pregnant women and children
- Individuals receiving SSI
- Elderly, blind and disabled
- Low-income Medicare beneficiaries

States have additional options for coverage, including daycare and taxi rides to and from appointments. They may also choose to cover other groups, such as individuals receiving home and community based services and children in foster care who are not otherwise eligible.

The Affordable Care Act gave states the opportunity to expand Medicaid by raising the federal poverty level to 133 percent for children and adults. The majority of states chose this option.

Modified Adjusted Gross Income (MAGI): This is the methodology used to determine income eligibility based on taxable income and tax filing relationships. This methodology was established by The Affordable Care Act.

Medicare Savings Programs: A program in which Medicaid pays Medicare premiums, deductibles and/or coinsurance costs for beneficiaries eligible for both programs. When a patient has this program, they are referred to as being dual eligible.

Presumptive Eligibility: Hospitals and qualified physicians have the option of screening patients to see if they qualify for Medicaid. Based on the patient's self-attested answers to specific questions, they may be granted temporary coverage. This allows for providers to receive payment for services during their temporary status

[4] Medicaid enrollment report, March 2017.

period. The patient is encouraged to follow through with the complete application process in order to keep the coverage. Many Patient Access professionals are responsible for initiating the Presumptive Eligibility application.

Medicaid Coordination of Benefits: Medicaid is considered the "payer of last resort," meaning that all insurance policies or plans pay primary to Medicaid.

TRICARE

TRICARE is a healthcare program for military active, reservists, and retirees and families. The program is overseen by the Department of Defense (DoD). Active-duty service members are automatically enrolled in TRICARE. Retirees and their dependents can enroll in TRICARE but may have to pay for the cost of coverage. Tricare offers several different health plans:

- TRICARE Prime
- TRICARE Standard
- Tricare Select
- Tricare for Life (Medicare wraparound coverage)

Military Treatment Facilities (MFTs) are the principal provider for the member's healthcare needs; however, in certain circumstances and with authorization, Tricare members can receive care from civilian hospitals and providers.

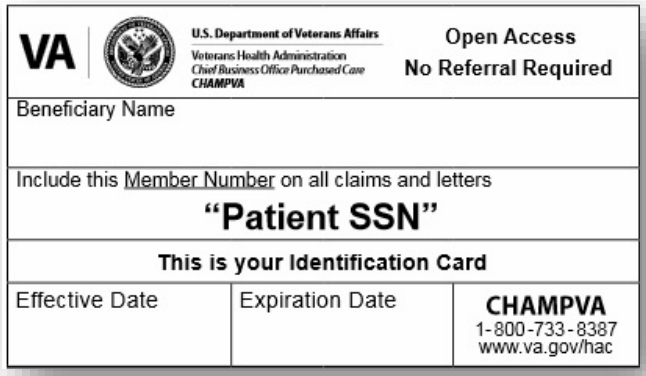
Coordination of Benefits

- Tricare is secondary to all other insurance plans, except Medicaid
- Tricare is not considered a group health plan

CHAMPVA

The Civilian Health and Medical Program for the Veterans Administration (CHAMPVA) is an insurance program for the families of veterans. Eligibility is based on the following:

- The spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by a VA regional office.
- The surviving spouse or child of a veteran who died from a VA-rated, service-connected disability.
- The surviving spouse or child of a veteran who was at the time of death rated permanently and totally disabled from a service-connected disability.
- The surviving spouse or child of a military member who died in the line of duty, not due to misconduct.
- Cannot be eligible for TRICARE.



Coordination of Benefits

- CHAMPVA is always secondary to Medicare
- CHAMPVA is secondary to other insurance plans except Medicaid

Veterans Administration (VA)

The Veterans Health Administration is the largest integrated healthcare system in America. The VA serves almost 9 million veterans each year. The VA has more than 1,700 hospitals, clinics and other facilities. Veterans are eligible for care through the VA if they:

- Served in the active military for at least 24 continuous months
- Were discharged or released under any condition other than dishonorable (some exceptions exist).

The goal is to provide our veterans healthcare at a VA facility. However, that isn't always possible. They may live too far from a VA facility, need a specialist that may not be available at the VA or it may take too long to be seen at a VA facility. In these cases, veterans may be referred to a community provider through the Community Care program. Referrals/authorizations to non-VA providers are always needed.

Veterans Choice Program

A program where the VA enrolled member is authorized to receive care from community-based providers. Care is authorized when their local VA health care facility is unable to provide services due to:

- Medical care at the VA is not available for at least 30 days or extended wait times for appointments
- Lack of available specialists in the area
- Patient lives more than 40 miles from a VA medical care facility
- When traveling creates excessive travel burdens

Regulatory Compliance Practice Questions

See page 142 for answer key

1. What is the CMS rule that states that an inpatient stay must cross two midnights to be paid for under Medicare Part A?

   a. Medicare 72-hour rule

   b. Medicare Two-midnight rule

   c. Medicare A Inpatient rule

2. Which program is responsible for protecting the integrity of the Hospital and Human Services (HHS) program by detecting and preventing fraud?

   a. CMS

   b. HITECH

   c. OIG

3. An effective compliance level has a minimum of how many levels?

   a. 10

   b. 4

   c. 7

4. All of the following are part of an effective compliance program except:

   a. Performing internal audits

   b. Creating standards of privacy

   c. Establishing standards, procedures and policies

5. EMTALA is a regulation which protects patient from what?

   a. Not being treating in an emergency due to lack of ability to pay

   b. Receiving prescription medication at the time of discharge

   c. Completing all their paperwork

6. All of the following are examples of PHI except:

   a. Patient names

   b. Computer IP addresses

   c. Financial assistance brochure

7. Meaningful Use is an incentive program to:

   a. Increase the adoption of qualified electronic health records

   b. Reduce the cost of care to the patients

   c. Increase the adoption of qualified paper documentation

8. This document is provided to Medicare beneficiaries who are admitted as outpatients receiving observation status that they may have a co-payment and co-insurance.

   a. MOON

   b. IMM

   c. ABN

9. All of the following are examples of fraud and abuse except:

   a. Billing for services not rendered

   b. Unbundling

   c. Unknowingly billing for services at a higher complexity

10. Which government healthcare program is provided for surviving spouses of veterans killed in the line of duty?

    a. Tricare

    b. CHAMPVA

    c. Veterans Choice

11. Tricare provides healthcare to all of the following except:

    a. Uniformed service members and families

    b. Survivors

    c. Civilians working in a military treatment facility

    d. Medal of Honor recipients

12. When a veteran's local VA healthcare center cannot provide service in a timely manner, this program allows the veteran to seek care from the community.

    a. Veterans Choice

    b. Tricare for Life

    c. CHAMPUS

13. Medicare is not considered primary payer in all of the scenarios below except:

    a. Medicare patient has ESRD and is in their 60 month of dialysis

    b. Medicare patient is over 65 and carries a GHP through their current employer with over 300 employees

    c. Medicare patient was in an auto accident and has liability insurance

14. The MSP requires that we ask pertinent questions to determine what?

    a. If Medicare is the primary source to pay for services

    b. If there are other sources of payment primary to Medicare

    c. If the individual has no insurance.

15. What is the form given to Medicare beneficiaries informing them of potential non-coverage of out-patient services?

    a. MAC form

    b. MOON

    c. ABN

16. Which of the following is a reason that organizations seek Joint Commission accreditation?

    a. It enhances community confidence in the quality and safety of care

    b. It is in-line with the Anti-Kickback Stature

    c. It is a requirement of HIPAA

17. The Important Message from Medicare (IMM) informs the patient of the following except:

    a. Their rights as hospital patients

    b. That if this inpatient stay is deemed experimental they will be responsible

    c. Instructions on what to do if they feel there are being discharged too soon

18. Method used to determine financial eligibility for Medicaid, CHIP and Marketplace cost sharing is called

    a. MAGI

    b. GNIE

    c. GIMGO

19. What is the name of the program also known as Obamacare?

    a. HFAP

    b. PPACA

c. HIPAA

20. Name of the statute created to ensure all people have access to emergency treatment regardless of their ability to pay.

a. EMTALA

b. PPACA

c. PCI DDS

21. What is the tracking code for patients admitted as inpatients to the hospital but do not meet the criteria?

a. Condition Code 44

b. CMS Code 22

c. Inpatient Code 17

22. Who is the primary payer when the Medicare patient is under the age of 65 and is covered by their spouses BCBS plan through the Federal Government?

a. Medicare

b. BCBS

c. Federal Health Benefit Plan

23. What is the time period when a Medicare patient on ESRD's group health plan is the primary payer?

a. 3-month coordination period

b. COBRA

c. 30-month coordination period

24. Methodology used to determine income eligibility for Medicaid:

a. MAGI

b. Dual Eligibility Standards

c. FPL 133

25. Name given when a provider screens a patient for temporary Medicaid coverage:

a. Temporary CV

b. Presumptive Eligibility

c. Self-Attestation Coverage Period

REVENUE CYCLE

Chapter Objectives

In this chapter, the student will learn to:

- Understand the revenue cycle and the role of Patient Access within it
- Identify data elements necessary for accurate billing
- Comprehend billing indicators for the UB-04 and CMS 1500 billing forms
- Verify payer plan coverage
- Comprehend the effect of the Affordable Care Act
- Determine coordination of benefits
- Perform point-of-service collection
- Provide and coordinate financial counseling
- Comprehend medical terminology and coding
- Collaborate with health information management
- Collaborate with patient's financial services
- Mitigate denials

Key Terms

- Ability to Pay
- Advance Beneficiary Notice (ABN)
- Bad Debt
- Carve-out
- Charity Care
- Clinical Trials
- COBRA
- Co-insurance
- Collections
- Coordination of Benefits (COB)
- Co-pay
- Current Procedural Terminology (CPT) (as pertains to reimbursement)
- Deductible
- Eligibility
- Exclusions
- Federal Poverty Guidelines
- Financial counseling
- HCPCS (as pertains to reimbursement)
- Medical necessity
- Medicare Secondary Payer Questionnaire
- Out of Network
- Out-of-pocket maximums

- Pre-authorization
- Pre-certification
- Propensity to Pay

Introduction to the Revenue Cycle

Revenue cycle is a term for the life of a patient account from creation to resolution. It reflects all the operational components under which a medical facility is reimbursed for services rendered to its patients. Although Access's role is traditionally at the front end of the revenue cycle, that role is expanding. Access role in revenue cycle varies depending on the medical facility. Being a cycle, there's really no end, and Access has a role to play at all stages.

- Components of revenue cycle include: scheduling, pre-registration, financial pre-requisites, medical necessity, arrival, registration, wayfinding, discharge, Q/A-billing pre-requisites, MR coding, billing, collections, bad debt.
- Access is considered the gatekeeper within the revenue cycle. It schedules the event leading to a patient encounter, creates the patient record and ensures that reimbursement requirements are met. Knowledge of third-party reimbursement, once a role of the back-end, is now front-and-center an access responsibility.
- Revenue cycle touches on many clinical aspects and financial/medical aspects, for which Access sometimes assumes responsibility. These include accurate scheduling, ensuring that incoming patients meet medical necessity requirements and obtaining/recording correct codes required for successful account billing.
- Many patients are unfamiliar with insurance and the other financial requirements that are so much a part of modern healthcare. Access staff increasingly are expected to help educate patients with matters involving account reimbursement; including insurance requirements, patient financial responsibility for deductibles, co-pays, etc., familiarization with the medical facility's assistance and charity programs and a general knowledge of the facility's collection procedures. The goal is for all patients to understand what is expected of them and what to expect. In this and so many other respects, Access plays a crucial role in the financial viability of healthcare institutions.
- Most aspects of modern healthcare are subject to government regulations, many of which pertain to day-to-day front-end activity. Access staff are expected to be familiar with rules pertaining to revenue cycle, such as EMTALA, HIPAA, etc. Explanations of these rules can be found on government web sites and sometimes in simplified, easier to understand form, on private medically-sponsored sites.
- Access' central role in Revenue Cycle requires that it establish relationships with other areas such as business office, physicians, nursing and technical departments throughout the facility.
- Access staff must understand the definitions of both financial and clinical terminology applicable to revenue cycle.

Financial Operational Overview

Revenue cycle is a term for the life of a patient account from creation to resolution. It reflects all the operational components under which a medical facility is reimbursed for services rendered to its patients. With respect to access, most reimbursement falls into one of three categories:

- Third patient commercial or government-sponsored payers (i.e., Blue Cross, Aetna, Medicare, Medicaid, Tricare)
- Other programs such as Worker's Compensation, research grants, clinical trials and studies, service contracts with employers, etc.
- Patient payments

In addition, medical facilities provide uncompensated and under-compensated care to patients who qualify for various charity programs and write-offs, plus unpaid balances that eventually go to bad debt.

Account flow through the revenue cycle influences several critical elements:

- Completeness and accuracy of patient demographic and financial information to ensure correct patient identity and billing.
- Completeness and accuracy of clinical information taken at time of scheduling.
- Medical necessity determination.
- Financial clearance to determine if and how the account will be paid.
- Proper completion of forms and signatures for compliance.

Access' role in the revenue cycle cannot be over-emphasized. Scheduling, pre-registration and registration functions are traditional access "gatekeeper" responsibilities. In the current healthcare environment, it is necessary to confirm a patient's financial arrangements and ensure that all billing elements are present and accurate prior to patient departure and in many cases prior to providing elective medical service. Failure to do this may result in the facility not being paid for the patient's treatment. Functions once performed by business office staff when an account was ready to be billed and collected are now assigned to access staff.

Access shares its revenue cycle role with other departments. Access work is the primary source of data used by business office staff in billing and collecting accounts. Access works with clinical areas during the scheduling phase and to obtain clinically-related data for pre-certification, medical necessity and billing. Access collaborates with Care Coordination/Utilization Review in obtaining pre-certification and medical necessity data and with Medical Records as source of demographic information to get the account coded. Access also works with Compliance Department staff to ensure that the data collections policies and procedures meet local, state and national standards.

Requirements for Accurate Third Party Billing

One of the standard metrics of revenue cycle performance is how quickly a third party is billed after patient services are completed. Many medical facilities have come to realize that obtaining complete billing information before the patient arrives or while at the facility expedites claim submission. Some payers allow only one opportunity to submit a correct claim and will impose penalties or even denials for rebilled submissions. In addition, facilities routinely have contracts with payers that define not only what reimbursement amounts will be but also the criteria under which a claim will be eligible for payment. Increasingly it has become the responsibility of front-end patient access staff to obtain, verify and correct data required for clean claim submission as early in the revenue cycle process as possible in order to decrease rework and denials.

Access should be aware of and meet these standards.

- Precertification
- Medical necessity
- Correct diagnosis/CPT codes
- Accurate patient/insured name as it appears in payer's records
- Accurate policy, group and payer ID numbers

KEY POINT

Some payers only allow one chance to fix a claim before it cannot be reimbursed, and claims submitted after the allowed timeframe, potentially due to incomplete or inaccurate data, means the claim cannot be reimbursed and is lost revenue for the organization.

Regulatory Compliance

With the additional requirements to ensure accurate billing, access staff must be aware of regulatory requirements that impact the collection and use of such data. (See Regulatory Compliance chapter for more information.)

- EMTALA requirements in ED
- CMS requirements for MSP and ABN
- Condition Code 44 regarding whether services meet inpatient criteria (in conjunction with UR and physician orders); Medicare sets standards for patients qualifying for Observation care – patient may not understand the difference but must be informed. Medicare reimbursement differs from inpatient care and may impact the treatment the patient qualifies for post-discharge. There is a trend for more Medicare patients to qualify for treatment under Observation status.

- Other patient notification requirements

Requirements for Collecting Patient-owed Balances

Patient-owed balances fall into two general categories:

- Accounts where patients have no third-party insurance or other coverage and do not qualify for charity or other assistance (aka True Self-Pay)
- Balances owed by patients before or after insurance pays

Before categorizing a patient as true self-pay, it is often necessary to provide financial counseling to patients who have no apparent third-party coverage to determine if they qualify for various studies, charity entitlements or other programs. Such assistance may serve to reimburse the facility for services, or it may reduce the account balance that subsequently qualifies as true self-pay.

Patients become eligible for charity assistance based on policies developed by the facility, usually based on the patient's income in relation to Federal Poverty Guidelines, which are often expressed as a percentage (e.g., 200% of FPG). The guidelines vary from year to year; current numbers can be looked up on the Internet. A facility's policy may vary based on the amount a patient owes. Patients with small balances may qualify only if their FPG percentage is low, while a patient owing a large amount may qualify based on a higher percentage. Facilities are subject to government audits to ensure that charity policy is administered consistently and equitably, regardless of the actual terms of the policy.

True self-pay accounts may qualify to be set up for monthly payment plans administered by the facility, by third-party vendors contracted by the facility, or by other payment arrangements such as credit cards, PayPal, etc. Sometimes these arrangements are handled by financial counselors, but many facilities delegate at least some financial counseling duties to Patient Access staff. Financial counselors often report to the Access Department. Because reimbursement is critical to the facility's financial health, all Access staff should be familiar with the facility's credit policies to be able to explain them to patients and not to provide misleading information that can compromise the patient experience.

Indeed, patients may be unfamiliar not only with a facility's self-pay policies but also with insurance reimbursement requirements in general. In order to enhance the patient experience and obtain data needed for prompt, successful billing, Access staff must be able to share their knowledge with patients in order to educate them on requirements and what to expect during the collections process.

Performance Standards

Healthcare leaders are always eager to know how their facilities are performing in terms of data collection, timely billing, accurate reimbursement and other revenue-cycle-related criteria. In the past two years NAHAM has developed a series of Access Keys that identify performance criteria, explain how to measure them, and provide

Good/Better/Best benchmarks for facilities to measure. Many revenue-cycle-related performance standards are dependent on advanced technology to obtain best results. While this doesn't mean a less technology-savvy facility can't succeed, the measures they use may be different. It is not practical to print the Access Keys in this document. Please refer to them by logging into the NAHAM website.

Data Elements Necessary for Accurate Billing

A persistent problem for hospitals is the high percentage of claims that payers reject resulting from inaccurate data entered during registration. For many hospitals, these inaccuracies remain the leading cause for claims being rejected or denied.

Additionally, incorrect Critical Data Elements (CDEs) result in returned mail and make it difficult to perform routine collection activities with the patient. Some of the CDEs that are commonly entered in error include:

- Patient name on claim not matching patient name on file with payer
- Incorrect or missing Member ID
- Claim submitted to wrong payer (e.g., traditional Medicaid versus Medicaid HMO)
- Incorrect address
- Missing or incorrect phone number(s)
- Missing pre-cert/authorization/referral information needed in order to submit claim

Confirming this information has been collected and is correct at the time of registration eliminates many downstream issues associated with billing payers and collecting from the patient, resulting in improvements to patient satisfaction.

Many Fiscal Intermediaries are using software that compares the diagnosis (ICD-10 code) to the service (CPT code) to determine medical necessity. Therefore, it is extremely important that the correct code is assigned to the physician's diagnosis and that it is as specific as possible. To help verify that codes are correct, many organizations use bill cleaners and bill scrubbers, which are types of software used to clean bills automatically according to preset rules before submitting claims to help reduce errors.

For professional services and most outpatient services performed at a hospital, Medicare pays by Ambulatory Payment Classifications (APCs). APCs are tied to CPT (Current Procedural Terminology) codes, which are used for coding procedures. The payment rate established for each APC is calculated based on the national average cost (operating and capital) of the hospitals.

Authorization Requirement – Certain services need authorizations, while other procedures might not. Some insurance companies require a CPT code, so make sure you have that available.

Billing Indicators and Billing Forms

It is important that information collected during patient registration is accurate because it flows through the revenue cycle and is used in many places, such as the UB-04 and CMS 1500 billing forms. Information collected is used to fill out the boxes on the forms in order to be reimbursed for services.

CMS 1450 (UB-04): A revised version of the UB-92, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice. Uniform bill is mandated by the Centers for Medicare and Medicaid Services (CMS) for use by hospitals, skilled nursing facilities, home health agencies, community mental health facilities, etc. “Form locator” is the name of the data fields on each of the uniform bills (i.e., UB-04). The UB-04 has 81 numerically sequenced form locators, while the 1500 has 33 form locators. Sometimes the form locators are referred to as boxes, such as Box 1, Box 4.

Co-pay CMS 1500: CMS 1500 is used by physicians and other clinicians. It is a fixed amount that the beneficiary pays for healthcare services, regardless of the actual charge; the amount is designated by an insurer as the patient’s responsibility. Most health maintenance organizations (HMOs) and preferred provider organizations (PPOs) have co-pays for emergency and urgent care visits; many waive the co-pay if the patient is admitted. Some insurance companies call this “cost-share.”

Payer Plan Coverage

Financial Concerns and Patient Needs

Hospitals provide medical care regardless of race, creed, color, sex, national origin, sexual orientation, disability, age or the ability to pay. Hospitals respect the medical needs of all people who come to their doors and the financial concerns of those with limited resources. Hospital personnel are experienced in working with insurance companies and government agencies and should assist patients in determining how accounts are to be paid.

In accordance with Section 501(r) regulations through the Affordable Care Act, a hospital must establish a written financial assistance policy and make it available to patients. A financial counselor can help determine what financial assistance is available to a patient and apply for financial help.

If enrolled in Medicare or Medicaid, the patient should present a current identification card at the time of registration. This information may also be obtained via the website. If the patient is not enrolled, but thinks that he or she may be eligible, hospital personnel should refer the patient as appropriate to state officials for eligibility.

Insurance

Patients with healthcare insurance should present their insurance cards at the time of registration or admission. Not all patients have their card – this does not mean that we turn them away, it simply means we need to obtain the information another way or discuss other payment options. Not all patients are familiar with the benefits,

limitations and coverage of their health insurance plan, but it is still their responsibility. They will depend on you when you are verifying their coverage to check benefits and to verify costs if hospital staff members are out-of-network providers, as patients may have a greater financial responsibility. (See financial obligations for scheduled services.)

Patients without insurance may contact the Patient Financial Services department at any time to arrange monthly payments or to investigate possible financial assistance. Payment arrangements should be offered if appropriate as established by your facility. POS staff may offer payment options depending on hospital processes and procedures and can refer to financial counselors.

Verification of Benefits

The first step is verifying insurance eligibility either through calling the insurance company, verifying through the insurance company's verification tool, or by verifying through a third-party eligibility validation product. Many healthcare organizations now subscribe to third-party eligibility validation products, which consolidate eligibility validation for their main payers in one application. Patient Access staff can send an eligibility request into the application, and an eligibility response, or report, is returned with eligibility status and other necessary information. It is important to verifying eligibility, since this can determine what services are covered and if the member is currently eligible.

Image Source: https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html

Image source: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42544_42644-381902--,00.html

Once the type of visit is determined, you will be able to gather all necessary information for that particular plan. You must be aware of the type of plan it is (HMO, PPO, etc.). By learning to read insurance cards and eligibility status reports returned from the payer, much of the information required for billing, such as eligibility, type of plan and copay, can be determined. Be sure to determine the following:

Insurance eligibility – The person is entitled to benefits and is covered. The date they became eligible for the plan is important to know since information can change from month to month.

Authorization Requirement – Certain services need authorizations, while other procedures might not. Some insurance companies require a CPT code, so make sure you have that available. Some registration systems, but not all, have software that alerts staff to the need for authorization for certain services.

Pre-certification/Pre-authorization – Certain insurance companies require pre-certification or pre-authorization from the primary care physician (PCP) prior to services being performed.

Out-of-Pocket Maximum – The total payments toward eligible expenses that a covered person funds for him/herself and/or dependents. These expenses may include deductibles, copays and coinsurance as defined by the contract. Once this limit is reached, benefits will increase to 100 percent for health services received during the rest of that calendar or policy year. Deductibles may or may not be included in out-of-pocket limits.

Deductible – The amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will begin to pay for eligible benefits.

Copayment – A payment that must be made by a covered person at the time of service. Services that require a copay, and the predetermined amount payable for each service, are specified in the policy. Copayments may be required for physician visits, prescriptions or hospital services.

Coinsurance – The percentage amount that is payable, per policy provisions, toward medical costs after the deductible has been met. For example, a patient's coinsurance amount may be 20 percent, and the insurance company's coinsurance could be 80 percent under a contract.

Carve Out – A decision to separately purchase a service, which is typically a part of an indemnity of an HMO plan. For example, an HMO may "carve out" the behavioral health benefits and select a specialized vendor to supply these services on a stand-alone basis. Carve outs may also include medical devices that the plan pays for in addition to the contracted per diem or case rate. Pre-certification/pre-authorization is often required for these benefits and services.

Lifetime Maximum – What is their lifetime maximum? Many payers have a calendar year and a lifetime maximum limit on benefits paid. Once the maximum has been reached, the benefits have been exhausted. There are no more funds available for coverage of any further services.

Exclusions – Certain procedures are excluded from the plan. Asking the insurance company will let you know what services are *not* included and covered in the plan.

Verification of Physician **–** Be sure to verify that the physician who will be treating the patient is on the panel of providers for the patient's insurance. This is especially important when a patient comes in who is unassigned (does not have a primary care physician) and will be accepted by the physician on call.

The next step is to contact the patient. Inform them of their responsibility, as they do not want to be surprised at the time of service. Verify all demographic and insurance information.

Access representatives have a significant responsibility for the accurate collection and verification of insurance. They must know the questions to ask to obtain complete employment and insurance information. Employment information is important because it can affect coordination of benefits, eligibility for specific types of insurance and financial assistance.

Payer Authorization

"Authorization" means a determination required under a health benefits plan, which based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity.

"Medical necessity" or "medically necessary" means or describes a healthcare service that a healthcare provider,

exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms. It must be in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the covered person's illness, injury or disease. Services are not primarily for the convenience of the covered person or the healthcare provider, and are not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

Determine coordination of benefits

Coordination of benefits (COB) is a way of determining the order in which benefits are paid, and the amounts that are payable, when a patient is covered by more than one health plan. It is intended to prevent duplication of payments when a patient is covered by multiple group health plans for the same medical service.

In an effort to standardize the coordination of benefit rules, the office of the National Association of Insurance Commissioners (NAIC) drafted model regulations in 1970. Many states have adapted some or all of the NAIC regulations.

When you verify a patient's insurance benefits, follow the insurance company's instructions as to which plans are primary. The combination of state and federal laws governing the regulation of insurance plans is very complex.

When verifying benefits for dependent children and both parents have the child under their health plan, the **birthday rule** determines which plan will be primary. The plan of the parent whose birthday (using the month and day) occurs earlier in the year is primary.

BIRTHDAY RULE

According to the birthday rule, the primary plan for a child is the health plan of the parent whose birthday comes first in the calendar year. Remember this is the date, not the year. If both birthdays fall on the same day, then the plan that has been in effect longer is primary.

For example:

Timothy's mother's birthday is January 27, 1985. Timothy's father's birthday is March 4, 1983. The mother's insurance would be primary for Timothy because her birthday occurs first in the calendar year.

When the parents are not together and a court decree exists naming the parent responsible for covering a child, that parent's plan is primary.

When the parents are not together and there is no court decree or healthcare coverage stipulation, the benefits for the child are determined in the following order:

- The plan of the parent with custody of the child is primary.
- The plan of the stepparent (spouse of the parent with custody) is primary.
- The plan of the parent who does not have custody is primary.
- The plan of the stepparent (spouse of the non-custodial parent) is primary.

You will need to contact the patient to review insurance information.

- The primary plan is contacted for authorization and billed for all services rendered. They make the first payment as if no other coverage existed except this plan.
- The secondary plan is billed after the primary plan has made the maximum payment allowable on eligible expenses. The secondary carrier calculates benefits as though there was no other coverage. They then pay the lesser of the calculated amount and the balance the primary carrier has submitted.

Perform Point-of-Service Collection

Point-of-service (POS) collection means collecting the patient's portion of the bill at the time service is rendered. As the burden of healthcare costs is increasingly moving to the patient, it is vitally important that payment collections are addressed earlier in the revenue cycle process. When registering scheduled patients, there are very few restrictions on asking for money at the time of registration.

However, a few regulations and contractual arrangements determine when and how much we can collect from a patient. Some examples include:

- EMTALA mandated that patients presenting for emergency service must have a medical screening exam and be medically stable before we can ask for payment.
- Third-Party Payers – always discuss payment with the patient or spouse, unless the patient has given written permission to discuss payment with the third party.
- CMS Guidelines mandates that collection policies used for Medicare patients be consistent with the policies for any other patient.

Be sure to check with your facility for the collection policies.

- Selecting the correct patient and account number is the most important key when posting payments.
- All payments must be recorded on your department's daily cash sheets.
- All patients making payments must receive a receipt.
- Note any other relevant comments, such as the date the patient will make the next payment, or if the patient was advised of other balances.

- Access representatives working in outpatient departments are responsible for collecting deductibles and copays whenever possible. This may be our only opportunity to speak with the patient, so be sure to verify *all* demographics.

For patients who cannot pay their portions in full at the time of service, they may need to make payment arrangements. Ask questions, suggest payment methods, and make every effort to collect the full payment before offering alternatives.

Some patients will have a true financial need. If you identify a person who truly appears unable to pay, have the patient fill out a financial assessment statement or charity application to assist them in determining if they qualify for any of the under-insured/uninsured programs, or refer the patient to a financial counselor.

Provide and Coordinate Financial Counseling

Financial counseling could also be called "financial investigation," as it is the method through which the provider identifies actual payment sources and alternatives. A financial counselor must review every uninsured or under-insured patient to determine a valid source of payment in order to minimize un-collectables. This should be seen as a patient support service, not a collection agency.

SOURCES OF FUNDING

Financial counselors help to educate patients about their insurance benefits, total treatment cost, payment policies and out-of-pocket expenses. They also help to determine patients' financial needs and find alternative sources of funding that are available to the patient.

Sources of funding may include the following:

- Government insurance (such as Medicaid)
- State, local, or hospital programs and charities
- Grants or studies
- Liability insurance (such as homeowner's)
- Victim's reimbursement funds

Medical Terminology and Coding

It is vital that Patient Access employees understand and accurately spell medical terms. Physician orders must be reviewed and the diagnosis and procedure information accurately captured to provide the appropriate service. Many facilities distribute a list of approved abbreviations to both clinical and non-clinical staff in order to provide clarity to any abbreviations used in the patient's medical record. Patient Access staff who need this information should ask their supervisor if this exists at their facility and, if so, who to obtain it from.

In addition to medical terminology, Patient Access employees should understand the classification systems used to translate narrative diagnosis and procedure information into universal numeric and alphanumeric codes that are used to process insurance claims and report specific clinical information to government and performance improvement organizations.

International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-10-CM) is the accepted diagnostic coding system in the United States. The ICD-10-CM classification system includes diseases, injuries and procedures. Originally, ICD-9-CM was developed 30 years ago, but it became outdated and could not accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century. Therefore, the updated system, ICD-10-CM, was developed and implemented October 1, 2015, per the CMS. ICD-10-CM contains an increased number of codes (from approximately 13,600 to 68,000) and categories that allow for a more specific and accurate representation of current and future medical diagnoses and procedures. Many facilities either have a code lookup tool built within the HIS system, or a separate lookup software application available, which Patient Access staff can use when a code is needed.

Healthcare Common Procedure Coding Systems (HCPCS) is used to classify items and services provided in the delivery of healthcare. HCPCS is divided into two levels. Level I is Current Procedural Terminology (CPT) and is used to classify services provided by physicians, hospitals and ambulatory surgery centers, and Level II is HCPCS codes used to classify non-physician services.

Health Information Management

Data Integrity refers to the process of ensuring that data is consistent and correct. In order to verify that data is accurate and reliable, Patient Access must develop a consistent process to measure quality and verify the accuracy of the data collected.

The primary role of Patient Access is to create the basis of the medical record through the capture of specific information prior to the patient's encounter or at the point of entry into the healthcare system. In order to understand how to measure and report data integrity, it is first important to understand the types of data elements captured during the registration process. Then, review the types of quality measurement processes that can be used to verify the accuracy of the data reported and report the accuracy rate to compare with internal and external benchmarks.

In Patient Access, staff members gather data that is classified into two broad categories: administrative data and clinical data. Administrative data is further divided into three subcategories: demographic data, socioeconomic data and financial data.

These individual data elements do not have meaning until they are combined together to form the patient's record. This data has a direct relationship not only to patient care but also to the financial integrity of the healthcare facility.

The basis of proper patient identification begins in Patient Access. Legal name and date of birth are the most common data elements used to identify the patient. These elements will be used throughout the healthcare encounter to verify the patient's identity prior to any service or procedure, thus adhering to TJC Patient Identification standards and other regulatory guidelines. In addition to name and date of birth, Patient Access associates may also obtain the patient's Social Security number, address, telephone number, place of employment and employment status, retirement or disability status, marital status, race or ethnicity, and insurance information. With a heightened awareness of protecting the patient's Social Security number, some facilities are no longer requiring a Social Security number as a patient identifier. A number of the data elements captured at the time of registration assist in meeting the patient identification requirements. Additionally, that data provides valuable statistical, clinical and financial information throughout the healthcare encounter and revenue cycle.

Proper quality measurement programs will have processes in place to verify that the administrative data captured during the registration processes are consistent and accurate.

The main repository used in Patient Access is the Admission, Discharge, Transfer (ADT) system. In this system, staff will either link the patient to an existing medical record by verifying data captured during the registration interview with the data housed in the Master Patient Index (MPI) or create a new medical record.

The MPI is the primary patient tracking link and therefore considered the most important resource in a healthcare facility. The MPI is used to match patients being registered for care to their medical record and minimize duplicate medical records.

IDENTIFY THE CORRECT PATIENT

It is vital to verify the correct patient has been selected by using at least two patient identifiers when searching for a patient.

Selecting the wrong patient can lead to incorrect information in a patient's record, or worse. Imagine what could happen if the wrong medication was given to a patient due to selecting the wrong patient!

Not finding the correct patient in the first place can lead to duplicate records and incomplete medical data. The doctor could receive only one part of a patient's medical record, the rest being in another file that may not be found.

In many instances, a patient has had previous encounters with the healthcare facility and the Patient Access staff member is charged with linking the patient to the existing medical record in the MPI. Failure to link the patient to the correct existing medical record number may compromise patient safety and negatively impact the ability of the organization to obtain payment for services.

Although not considered a clinical department, Patient Access is responsible for the capture of specific clinical information necessary for the patient healthcare encounter and claims billing processes. Through the review of the scheduling information and/or physician order, Patient Access must capture the reason for the encounter or admitting diagnosis and the procedure information, if appropriate. Accurate capture of this clinical information impacts medical necessity and utilization management protocols.

In order to support the clinical departments, Patient Access may be responsible for obtaining a valid physician order. Components of a valid physician order are:

- Legibility
- Patient name
- Date (must be within specified timeline – 30 days or as defined by state statute and/or facility policy)
- Test or therapy ordered
- Diagnosis, signs or symptoms
- Physician signature

Mitigating Denials through Data Accuracy

Patient Access must develop a consistent method of auditing for accuracy. A manual system to review and report data accuracy may be used, but in recent years, electronic quality assurance systems have been designed to provide real-time and/or batch accuracy verification processes, thus allowing the Patient Access department to confirm the integrity of the data captured earlier in the revenue cycle.

Benefits of an automated Quality Assurance process are:

- 100% of registrations audited
- Patient Access associates receive feedback on errors and can self-correct
- Errors corrected earlier in the revenue cycle
- Clean data before the bill drops

Internal auditing provides a snapshot of the results produced by current processes. Accuracy of the registration data results in fewer denials, rejected claims and other delays. Accurate registration can also lead to timelier and increased payments as well as an overall better patient experience.

Data measured are used to implement performance improvement initiatives designed to meet the revenue cycle goals of reducing accounts receivable (A/R) and improving cash flows for the organization.

Revenue Cycle Practice Questions

See page 142 for answer key

1. Which of the following is not part of the revenue cycle:

   a. Patient scheduling
   b. Insurance verification
   c. Final billing
   d. All are part of the revenue cycle

2. Which statement about Coordination of Benefits is false?

   a. It is determined by accurately answering questions in the Medicare Secondary Questionnaire
   b. It applies to patients covered by one insurance plan
   c. Incorrect determination can result in delay in claims reimbursement
   d. Access staff have a responsibility to determine correct Coordination of Benefits

3. Access's role in revenue cycle is enhanced by staff training in which of the following functions, except:

   a. Insurance verification
   b. Financial counseling
   c. General knowledge of billing requirements
   d. Patient's diagnosis

4. NAHAM has developed a series of guidelines that identify performance criteria, explain how to measure them and provide Good/Better/Best benchmarks for facilities to measure. These guidelines are called:

   a. Access Keys
   b. Map Keys
   c. Revenue Cycle Keys
   d. Keys to Success

5. Which is not an example of how Access staff influence the revenue cycle?

   a. Accurate gathering of patient data helps to ensure timely reimbursement.
   b. In many facilities Access has taken over responsibility for financial counseling.
   c. Insurance pre-requisites and high patient deductibles has emphasized focus on front-end processes.
   d. Kiosks in the Access areas have resulted in shorter patient wait times.

6. All of the following should be reviewed when checking insurance eligibility, except:

   a. Patient name and date of birth

   b. Active insurance benefits

   c. Date became eligible

   d. When eligibility ends

7. What is a deductible?

   a. Payment made to pay for your insurance each month

   b. The amount of the hospital bill not paid by insurance

   c. The amount the insurance company requires you to pay before insurance pays

8. Successful insurance verification doesn't automatically mean insurance will pay for charges incurred during a visit.

   a. True

   b. False

9. A minor child is brought in with insurance from both parents. The mother's birthdate is July 15, 1993. The father's birthdate is February 20, 1995. According to the birthday rule, whose insurance is primary?

   a. The mother's insurance

   b. The father's insurance

INFORMATION SYSTEMS

Chapter Objectives

By the end of this section, learners will be able to:

- Manage timely input of data
- Comprehend the impact of patient management system transactions (e.g., electronic data interface, electronic medical records and ancillary systems)
- Recognize the purpose of downtime or mass casualty procedures and reconciliation

Key Terms

- Server
- Mainframe
- Network
- Interface
- Data repository or data warehouse
- Master Patient Index
- Batch processing
- Real-time
- Contract management
- Downtime
- Recovery
- Crash
- Protocol
- Electronic Medical Record
- Firewall

Introduction to Information Systems

- All aspects of modern healthcare rely on Information Systems (IS) to support expected levels of clinical care, clerical administration, financial collection and reimbursement, data retention, statistics, finance, reporting, risk management, quality review and patient identification.
- IS has saved work time and effort and promoted work efficiency and unparalleled levels of productivity compared to manual efforts.
- IS facilitates the management of huge volumes of complex clinical, financial and demographic data.
- IS expedites communications and data sharing among facilities.
- If well-managed, IS has the potential to enhance security and data integrity. If used carelessly, it has the ability to compromise security and data integrity on a massive scale. It is the responsibility of Access staff to use automated systems safely and in accordance with medical facility guidelines, as well as to be familiar with and observe all regulatory rules, such as HIPAA.
- Systems throughout the medical enterprise are often linked or interfaced; changes to one system often impact others. Awareness of these interactions is critical to ensuring a seamless, smooth-running medical system.
- Access staff should have a working knowledge of how IS departments manage their work via such constructs as help desks, hardware and software support, software development, project management, resource management, vendor management, security management, website/portal management, system integration/compatibility, system security and project budgeting. Such knowledge guides staff on who to contact for help with various system-related problems. It also lays the groundwork for managing departmental projects, working with outside vendor setups and interfaces, and other access work requiring IS assistance.
- The Internet and facility Intranet play an increasingly important role in modern healthcare. Communication with patients via portals or on handheld devices has become commonplace and is thought to enhance the patient experience.
- Basic computer skills and terminology are givens in the modern Access environment. Not only is this essential to the job itself, it also promotes successful communications with IS department and desktop staff.
- Modern healthcare relies on IS to support all aspects of medical practice. Online automation provides the framework on which enormous quantities of data can be organized and accessed to manage the patient's clinical, clerical and financial experience. Automation has become such an integral part of an Access employee's job that it may go unnoticed until something goes wrong. When that happens, it is important for Access staff to understand IS' role, as well as to know how to perform essential workarounds to keep the department running.

Information Technology in Healthcare Organizations

Despite variations in the hardware and software from one organization to another, the information obtained through computerized technology is used to serve similar purposes.

IS provides:

- Integrated support for all departments within entire health organizations
- Identification of patients or records uniquely
- Automated functions in the financial, clinical and administrative areas
- Improved patient care
- Facilitation for reimbursement of services rendered
- Easier access to clinical and administrative data
- Timesaving automation of tasks that would otherwise require staff time and attention

Functions of an IS department in a healthcare organization frequently include all or most of the following:

- Supporting installed technologies
- Providing safe and secure information network(s)
- Partnering with customers to select, implement and integrate systems that address business needs and optimize the use of available funds
- Providing appropriate education for the use of hardware and software systems
- Integrating data and processes to provide value-added information
- Advising, monitoring and ensuring data integrity through analysis and support

Automation in the Access Department

Nearly every step in the revenue cycle that involves Access also brings automated systems and processes. Here's an example of that progression:

- Scheduling the patient visit
- Obtaining necessary codes and prerequisites for medical necessity
- Clerical pre-registration (by Access staff or by patient on a portal)
- Financial clearance
- Arrival (by Access staff or at a kiosk)
- Scanning, storage and retrieval of patient documents such as insurance cards, approval letters, etc.

- Up-front cash collection
- Patient tracking (and bed assignment for inpatients)
- Discharge
- Pre-bill editing and Q/A

Features of Healthcare Systems Dependent on IT Systems

Many routine Access functions that are practically taken for granted rely on Information Systems for maintenance and support.

- Master Patient Index (or Enterprise Patient Index)
- Patient data collection and processing systems, such as scheduling, pre-registration, registration, authorization and verification
- Clinical Data Repositories (or Data Warehouse)
- Nightly Batch Processing
- Connectivity to insurance and government websites for insurance information
- Automated payment systems
- Automated calling systems
- Kiosks
- Patient portals

Data Integrity

Automation can be a help or a hindrance in ensuring patient identity and securing protected patient information to meet HIPAA and other compliance regulations.

Examples include:

- Selecting the correct record/account number at the time of scheduling for patients with previous visits to the facility
- Patient identity technology such as palm-vein, retinal, facial recognition and fingerprints
- Automated insurance verification/certification, ability to pay/propensity to pay software
- Availability of websites on which Access staff perform verification/certification and obtain other patient-related data
- Online patient registration

- Secure online identity, storage and viewing of patient documents
- Sharing of data collected by one system (i.e., admission-patient accounting) with other systems, such as clinical and medical records
- Determining appropriate levels of security access for staff who use automated systems

Downtime

Automation has become so much a part of contemporary healthcare that we tend to take it for granted. Even the best systems are out of service from time to time, sometimes intentionally for scheduled maintenance and upgrades, other times not. While a full back-up system may be technically possible, most facilities are faced with partial or complete unavailability of automated systems from time to time. This is called downtime. It applies both in clinical and nonclinical environments. How well nonclinical departments manage downtime has direct impact on the safety and clinical care of patients.

Downtime falls into two general categories:

Scheduled downtime occurs on a predictable basis. Procedures for conducting business during these periods are typically well-documented in the Access Department and may involve collecting patient data manually and entering it online in a timely manner when the system comes back up. Scheduled downtime may occur nightly or at other periodic intervals and may affect some departments more than others. It also may occur in association with projects involving system enhancements, upgrades and conversions. The IT department typically notifies departments of these events well in advance. Access departments should maintain detailed, well-documented downtime procedures to implement during such periods. These procedures should be coordinated with all departments that Access works with to ensure a compatible work flow and minimize inconvenience to patients, physicians and other department customers. Examples of downtime procedures may include rules regarding manual patient registration, communications with other departments and procedures to address the functions of all systems used in the department.

Unscheduled downtime is when one or more systems fail to function, often negatively impacting other interfaced systems. The source of the outage may be external, such as a natural disaster, or internal, such as a system crash. Because unscheduled downtime is likely to impact systems throughout the enterprise, Access' role is often defined by a facility-wide plan similar to disaster-related plans. In fact, unscheduled downtime may be regarded as a subset of a facility's overall disaster plan. Emphasis on ensuring appropriate patient care over an unknown but possibly extending period is top priority. So too is the role of safeguarding patient identity and maintaining a functional environment.

When a system comes up after a period of downtime there is typically a transitional "catch-up" period. If the system has been down for an extended period, the catch-up may be referred to as recovery. Recovery may

involve IT using back-up systems to restore data to pre-downtime status. It may also require the input of data manually collected during the downtime. Recovery may range from a period of relatively minor inconvenience to a prolonged period of diminished functionality and data catch-up, depending on the downtime's duration. Access Department recovery procedures should be well-documented and coordinated with those of other departments. Throughout such periods patient care remains the top priority.

Role of IS Department as It Pertains to Access

Information Services (a.k.a. Information Technology, or IT) departments support the hardware and software inventory that healthcare facilities use to conduct business. Such support can be provided internally by staff employed by the facility or contracted to vendors who are not facility employees. Functions of IS staff include:

- Managing automated and manual programs necessary to ongoing operation of the facility
- Maintenance of hardware used by departments
- Providing leadership and support for new automated products and upgrades
- Providing leadership and support for system interfaces among internal and external systems
- Downtime and recovery procedures/processing
- Providing secure, compliant access to systems for staff
- Availability of desktop support to address malfunctioning/broken software and hardware and facilitate staff moves
- Data storage and retrieval via scheduled and custom reports
- Maintaining a help desk or other means of recording and tracking system issues
- Working with outside vendors to provide and receive data via interfaces, transmission files and other compliant means
- Managing and/or participating in system-related projects and providing a means of monitoring system change requests (change control)
- Working with outside vendors to assess product compatibility with existing systems

While an Access employee is not expected to be fluent in IS-related terminology, it is helpful for staff to have a basic understanding of things IS does and does not do. IS is all about communications. A basic understanding of the IS role and common terminology (see Glossary) can help IS identify and resolve technical issues that occur in Access.

Computer systems are comprised of hardware and software:

- Hardware: includes keyboards, monitors, central processing units (CPU), servers, printers, cables and cords, credit card machines, kiosks, ten key pad, web cameras, tablets, interpreter system, etc.
- Software: includes systems programs that make the computers run (operating systems such as Windows and DOS), application programs (registration program, QA, eligibility, address verification, medical necessity) and interfaces

Hot Spots, function keys and icons are all shortcuts to other pathways, functions or programs and are good examples of the potential confusion between hardware and software. If clicking on an icon does not bring up the anticipated program, it could be the result of a problem with the mouse (hardware) or a program (software). The more Access associates know about the computer systems they use, the more they will be able to troubleshoot on their own or more easily explain the problem to the IT staff so it can be identified and resolved.

Typically, Access associates enter data in software applications such as patient management or registration systems. The data is stored to make it readily accessible to authorized users and is shared with other healthcare information systems. Common ways data is transmitted include:

- Batch processing – many transactions are stored and sent on a prescheduled or demand basis
- Interfaces – software takes data from one system and sends it to another, frequently reformatting it to be acceptable to the system

Data collected in Access is shared with many other applications, including:

- Financial management systems – billing, reimbursement, etc.
- Patient care systems – lab, radiology, nursing, etc.
- Administrative systems – decision support, quality review, etc.

Data integrity is an essential part of Access Services because errors made in registration and admissions are transmitted to all these other systems and can impact patient care as well as the financial health of the organization.

As healthcare continues to evolve from traditional independent hospitals to integrated healthcare networks (IHN), their information processing needs are changing. This consolidation and restructuring requires that the traditional healthcare information system evolve to accommodate the need to coordinate activities of many different facilities or organizations. Patients who travel between care providers within a healthcare system need to be identified in some unique manner. Basic information collected at one site should be available to other providers in the network.

Systems and Interfaces

Medical facilities typically have multiple systems on which staff do their work. Some facilities tend to use products from one vendor on the theory that they are designed to work together in data sharing. Other facilities use products from different vendors that are connected by means of interfaces. Accuracy and dependability of interfaces is critical to the operation of all systems. Interface breakdowns can lead to critical downtime situations and potential compromise of data accuracy and integrity. Access staff are familiar with scheduling, registration and billing systems. Staff has general knowledge of clinical systems to which Access systems pass demographic data and from which they receive clinical data for billing. Medical records systems interface with clinical and registration/financial systems to provide essential billing information. Other “add-on” systems may include contract management, insurance verification, insurance certification and Q/A, all of which impact Access’ role in the revenue cycle. Other more HR-related systems include time-and-attendance and payroll.

Information Systems Practice Questions

See page 142 for answer key

1. Which of the following is **not** an example of technology used to ensure positive patient identity?
   - **a.** Palm vein
   - **b.** Kiosks
   - **c.** Facial recognition
   - **d.** Retinal

2. An interval when a system is unavailable to users is called:
   - **a.** Blackout
   - **b.** Downtime
   - **c.** Manual registration
   - **d.** Batch processing

3. Which of the following functions is not typically supported by advanced technology?
   - **a.** Medical records coding
   - **b.** Insurance verification
   - **c.** Estimating patient responsibility
   - **d.** Explaining benefits to patients

4. For which of the following issues would you call for desktop support assistance?
   - **a.** Power failure in the building
   - **b.** Adding an icon to a computer screen to access a new function needed for work
   - **c.** PC won't boot up
   - **d.** Adding Facebook to your desktop

5. Which of the following is not a data source for an automated Access statistical report?
   - **a.** The facility's registration system
   - **b.** A standalone data repository or warehouse
   - **c.** The finance department
   - **d.** The electronic medical record

RESOURCE MANAGEMENT

Chapter Objectives

- Recognize the need for resource management (e.g., staff, time, equipment, funds)
- Understand quality metrics and productivity data

Key Terms

- HIPAA Notices of Privacy Practices
- Patient Rights and Responsibilities
- Point of Service Collections
- Quantitative Measurements
- Qualitative Measurements

Resource Management

Resource management is the efficient and effective utilization and deployment of an organization's resources when they are needed. Resources may include financial resources, supplies, human resources (staff) or IT.

One of our most valuable resources is time. The largest expense item in the Patient Access budget is salary. Management of this valuable resource requires a collaborative effort between staff and management. Outsourcing staff may be another way to manage expenses. Salary expense can be managed by:

- Core staffing levels
- Flex staffing to volumes
- Management of premium salary expenses
- Overtime
- Agency
- Other premium pay programs (hospital-based)
- Improving productivity
- Years of experience
- Acuity level
- Seniority

Other important resources are the department's physical resources, including equipment and supplies. Patient Access associates should utilize equipment according to the instructions provided. Care should be taken to maintain the equipment, including routine cleaning and preventative maintenance. Equipment failure should be reported to management based on the facility's procedures.

Supplies, including forms, are typically the second largest budgetary expense. Forms may include HIPAA Notices of Privacy Practices, facility maps, patient instructions, etc. As facilities move toward electronic and online forms, there is a reduction in forms expense. Consistent effort should be made to ensure proper management of all supplies by:

- Reducing waste
- Controlling access to supplies
- Utilization of paperless processes
- Online tools
- Automation
- Review quality metrics
- Interpret productivity

Interpret Quality Metrics and Productivity Data

Productivity is the measure of labor output or production. In Patient Access, a standard productivity measurement is the number of patient registrations. There are other productivity measurements, including number of scheduling calls, insurance verifications, pre-certifications, financial counseling interviews, registration wait times, POS collections, quality metrics, QA system, address verification and score cards. Productivity can be:

- A quantitative measurement such as registrations completed in a specified amount of time (day, hour, department, per individual)
- A qualitative measurement such as accuracy of registrations completed

Productivity measures are used to not only monitor output (e.g., number of registrations) but the value of what is produced.

Each facility determines an appropriate measurement of productivity for their organization. In some facilities, productivity standards are established by departments outside of Patient Access, such as decision support or human resources, and results are reported to senior leadership. Productivity measurements are used to verify that the output (e.g., number of registrations) and the human resources required (e.g., number of Patient Access associates' worked hours) meet or exceed specified standards. Patient Access managers and supervisor are charged with monitoring productivity to adjust staffing levels according to volumes.

Simple Productivity Example – Quantitative

	Registration Department	Patient Access Associate 1	Patient Access Associate 2	Patient Access Associate 3	Patient Access Associate 4	Patient Access Associate 5	Patient Access Associate 6
Total Registrations	596	89	120	75	104	92	116
Hours Worked	43.50	6.5	8.0	5.0	8.0	8.0	8.0
Registrations per Hour	13.70	13.69	15.00	15.00	13.00	11.50	14.50

Simple Productivity Example – Qualitative

	Registration Department	Patient Access Associate 1	Patient Access Associate 2	Patient Access Associate 3	Patient Access Associate 4	Patient Access Associate 5	Patient Access Associate 6
Total Registrations	596	89	120	75	104	92	116
Errors	11	0	3	1	1	4	2
Accuracy Percentage	98%	100%	97%	99%	99%	96%	98%

Resource Management Practice Questions

See page 142 for answer key

1. One of our most valuable resources is:
   - **a.** Time
   - **b.** Money
   - **c.** Staff
   - **d.** Vendors

2. The largest expense item in the Patient Access budget is:
   - **a.** Supplies
   - **b.** Vendors
   - **c.** Equipment
   - **d.** Salaries

3. Which of the following is a common form used by Patient Access representatives during patient registration:
   - **a.** HIPAA Notices of Privacy Practices
   - **b.** Productivity form
   - **c.** Evaluation form
   - **d.** Clinical questionnaire

4. In Patient Access registration, a standard productivity measurement is the number of:
   - **a.** Scheduled calls
   - **b.** Patient registrations
   - **c.** POS collections
   - **d.** Quality metrics

5. Quantitative measurement in registration is measured by:
   - **a.** Registrations completed in a specified amount of time
   - **b.** Scheduled calls completed in a specified amount of time
   - **c.** Pre-registrations completed in a specified amount of time
   - **d.** Orders completed in a specified amount of time

Pre-Arrival

SCHEDULING

Chapter Objectives

- Identify accurate patient and record pertinent schedule information
- Arrange and schedule location, equipment and/or staff (resources)
- Identify insurance information required to schedule service (e.g., authorization, medical policy, referrals)
- Identify clinical information required to confirm service for a specific date and time (e.g., referrals, valid order)

Key Terms

- Ethnicity
- Propensity to pay
- Patient portal
- Charity care
- Affordable Care Act
- Patient experience
- Patient contact center
- Pricing transparency

Patient Schedule Information

Availability

It is vitally important to coordinate with the individual departments to assist them in maximizing their department productivity by managing their schedule and staffing resources accordingly.

Often you will receive calls from patients and physicians asking about services available at your facility. It is good customer service to be familiar with the availability of services and know what referral options are available in your community for services you do not offer.

Be flexible to walk-ins. Take a moment to acknowledge them if you are with someone and let them know an approximate time you will be available to help them. Keep them updated if things change.

Monitor/document no-shows and report back to the physician office at day's end for follow-up in coordination of care for the patient, and to keep track of equipment/resource downtime in each ancillary area.

Scheduling

The purpose of scheduling is to ensure there is staff, resources and equipment to meet the patient's needs and to:

- Achieve the maximum patient flow and to minimize patient wait time
- Ensure adequate staff is available to perform the service that the patient requires
- Ensure that the patient's old chart is available if needed
- Make sure that longer intake time is scheduled if the patient is coming for the first time
- Obtain insurance information for checking if prior approval is necessary and verify insurance eligibility
- Make sure all necessary forms and information are available when the patient arrives
- Ensure equipment is available and in working order for patient's needs
- Inform the patient if there is prep time needed and ask them to arrive early to ensure patient is ready by the procedure time
- Be aware of the department scheduling guidelines in order to ensure you offer patients the most appropriate and convenient options for scheduling their required services
- Be sensitive to any scheduling restrictions a patient may have – for example, they are preparing to leave town and need to have their services scheduled sooner rather than later, they have transportation restrictions or difficulties, they want their friend to be able to accompany them for support, etc. While this may make the task of finding an appropriate appointment for a patient a little more challenging, we must maintain the highest possible level of sensitivity to their needs.
- Keep in mind the patient's welfare and comfort. If the patient is to have fasting tests, for instance, make an effort to schedule them earlier in the morning to minimize the length of time they need to go without having a meal.

Proper scheduling will improve patient and staff satisfaction and will be a more effective use of time.

Documentation

- Confirm the appropriate patient is selected from the Master Patient Index to ensure accurate information is obtained and for the patient's safety.
- Advise patients to bring any required documentation to their appointment (insurance cards, identification, copy of order if provided, physician referrals, copay, deductible, out-of-pocket cost, etc.).
- Ensure the services scheduled are the services reflected on the physician order and the order is present and compliant before services are rendered.
- A compliant order consists of patient name, DOB, diagnosis, procedure, physician name and physician signature. Best practice recommends CPT and ICD-10 codes along with appropriate verbiage.
- If a patient has Medicare, ensure that medical necessity has been checked and that ABN has been provided and signed, if applicable.

- Validate insurance eligibility and calculate any out-of-pocket monies to be collected at time of service.
- Initiate authorization according to insurance guidelines and contracted payers and document accordingly to prevent future denials.
- Identify financial needs and refer to financial counseling those patients that are unable to meet payment terms according to the hospital's financial policy.
- Prior to the end of the call, repeat appointment date and time at least once (or request the patient repeat the information back to you) in order to confirm the patient has accurately recorded the appointment information.
- Provide any prep instructions as given by the department.
- Some hospitals contract with a vendor to provide appointment reminders via text, email or cell to help reduce no-shows.
- In many cases, it is useful to note special circumstances on the schedule with the patient's information. For example: "Patient requests a copy of results be faxed to Dr. Smith @ (760) 555-1212"; "Patient is not ambulatory and will need assistance standing"; "Non-English-speaking patient/translator required." Note: your facility may have an alternative method of documenting and sharing this information with the department.

Remember: document, document, document . . .

If it is not documented then it did not happen. Document as appropriate for your job description, in the manner chosen by your facility.

Dos

- Check that you have the correct patient
- Check that all required information is there
- Be concise – ask yourself, "If someone else reads this, will they know what is going on?"
- Record time and date of each phone call, who you spoke to, the message and the response
- Record follow-up information
- Write legibly
- Document insurance authorization numbers if available
- File appropriately so you can retrieve it at a moment's notice
- Be sure to include any problems that arise

Don’ts

- Do not use shorthand or abbreviations
- Do not record second hand information unless the information is critical. In that case, use quotations.

Scheduling System Applications

Be sure you know your facility’s requirements, department’s hours of operation and allotted time for each procedure, including prep time. Know how long it takes to do your job efficiently and effectively, and schedule appropriately.

Although registration and scheduling systems vary from one facility to the next, they are primarily similar in function. Regardless of the scheduling application, the following basic information will most likely need to be reflected on the scheduling grid:

- Patient name
- Physician name
- The service that was scheduled
- Diagnosis
- Date of service
- Time of service
- Duration of the appointment
- Any special directives or requests

Scheduling

Scheduling can be completed in a variety of ways – paper, electronic, self-schedule, and/or provider-schedule via centralized or de-centralized models. Robust scheduling systems have the ability to schedule a given test, the associated staff resource needed to perform the test and the available locations the test is offered. Effective means to coordinate these three components creates the most efficient process that will ensure maximum capacity staff utilization and increase revenue. The ability to identify the quickest appointment across an enterprise at a location convenient to the patient will ensure patient satisfaction.

Identifying Insurance Information

"Authorization" means a determination required under a health benefits plan, which, based on the information provided, satisfies the requirements under the member's health benefits plan for medical necessity.

"Medical necessity" or "medically necessary" means or describes a healthcare service that a healthcare provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms. It must be in accordance with the generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site and duration; and considered effective for the covered person's illness, injury or disease. Services are not primarily for the convenience of the covered person or the healthcare provider, and not costlier than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

Referral services are the parts of the process by which patients are referred to a healthcare provider. The primary customers of Patient Access are patients and their families, physicians and payers, but there are many subsets, such as nursing and physicians' staff. Patient Access Services customers are both internal and external. This can be accomplished through many different channels, such as:

- Physician to Referral Center to Physician
- Patient to Referral Center to Physician
- Managed Care to Specialist

Regardless of the channel, the goals should be to attain and maintain quality service and high levels of customer satisfaction, as well as sustain the referral flow.

Clinical Information

Certain procedures require clinical documentation "chart notes" in order to obtain authorization. Other procedures require a peer-to-peer review before authorization is given. Some authorizations are specific to a certain time frame based on the number of visits the patient may require – for example, physician therapy may have an authorization that covers 10 visits. Other authorizations may be specific to a location or tax ID, depending on how the contract is written.

Schedules should be reconciled by each respective ancillary department the day prior to ensure the appropriate test is scheduled compared to the order. Should an additional/alternative test be needed, it is required that the physician office be notified to provide an updated order and that the pre-authorization team is notified as well to ensure the appropriate authorization exists for any change in procedure prior to rendering service to prevent future denial.

Scheduling Practice Questions

See page 142 for answer key

1. What is the purpose of scheduling?

   a. To ensure there is staff, resources and equipment to meet the patient's needs

   b. To ensure physicians are happy

   c. To generate revenue for the facility

   d. To increase point-of-service collections

2. What documents should the patient bring with them to their appointment?

   a. Insurance cards, identification, physician order if available and physician referrals

   b. List of medicines

   c. Tax records

   d. None of the above, patients shouldn't bring valuables to the facility

3. What are the elements of a compliant order?

   a. Reason for ordering the test or service, service requested, patient complete name and date of birth

   b. Reason for ordering the test or service, test or service requested, provider's name, provider's signature, patient complete name and patient date of birth

   c. Reason for the test, test requested, cost of test, provider's name and signature

4. The part of the process by which patients are referred to a healthcare provider is called _____?

   a. Onboarding

   b. Centralized scheduling

   c. Referral services

   d. Pre-registration

5. When might additional clinical documentation be required?

   a. For certain payers in order to obtain authorization

   b. If the patient has recently been seen at another facility

   c. If the patient is a new patient

   d. None of the above, with electronic medical records, everything should be there

6. Appointment reminders help reduce _____?

   a. No-shows

   b. Cost

c. Volumes

d. Customer satisfaction

PRE-REGISTRATION

Chapter Objectives

In this chapter, the student will learn to:

- Utilize the electronic Master Patient Index to ensure accurate patient identification and safety
- Collect and record patient information
- Identify and collect accurate payer information and subscriber demographics
- Verify eligibility and interpret benefits
- Validate and meet payer requirements
- Secure prior authorization
- Information and/or collect customer financial obligations prior to service
  - Explain estimates and make payment arrangements
  - Screen for other state or federal program eligibility and/or identify need for financial assistance
- Identify testing and procedure prerequisites
- Review service or procedure information with patient
- Review wayfinding

Key Terms

- Ethnicity
- Propensity to pay
- Health exchange
- HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems)
- Patient portal
- Charity care
- Affordable Care Act
- Patient experience
- Patient contact center
- Pricing transparency
- CEHRT (Certified Electronic Health Record Technology)
- ONC (Office of the National Coordinator for Health IT)
- HIPAA (Health Insurance Portability and Accountability Act of 1996)
- Insurance eligibility
- Authorization requirement
- Pre-certification/pre-authorization
- Out-of-pocket maximum
- Deductible
- Copayment
- Co-insurance
- Carve out
- Lifetime maximum
- Exclusions
- Verification of physician

Registration Systems

As with scheduling systems, registration systems vary from facility to facility. NAHAM's Best Practice Recommendations (pg. 20) focus on the five data attributes identified in the 2015 criteria for Certified Electronic Health Record Technology (CEHRT) issued by the Office of the National Coordinator for Health IT (ONC) in 2016 as essentials for patient identification and matching.

- Patient name
- Date of birth
- Address(es)
- Phone number(s)
- Sex/gender

Listed below are additional data attributes intended to improve patient identity integrity, such as:

- Race
- Ethnicity
- Place of birth
- Father's name
- Mother's maiden name

Some organizations may also choose to collect the following elements at the point of registration for use in coordination of care, financial clearance and billing follow-up:

- Employment status
- Service type
- Employer information
- Service location
- Religious preference
- Language
- Advance directive information
- Email address(es)
- Next of kin
- Insurance information

Medical Record Initiation

Upon a patient's first registration at a facility, they will be issued a unique system identification number. This number may be referred to as an enterprise number, medical record number or master patient index number. This number will be used to coordinate the electronic or standard medical record for the patient on the initial and all subsequent visits.

Collection, Storage and Dissemination of Patient Information

A patient's medical records are reviewed on an ongoing basis for completeness of information, and action is taken to improve the quality and timeliness of documentation that affects patient care. Some things to note:

- A patient's medical record will be maintained for a minimum of 10 years.
- A patient can request a copy of their medical record at any time.
- A patient's signature will be required any time a non-referring/ordering physician or practitioner requests a copy of any part of the patient's medical record.
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives a patient his/her rights over his/her health information, including the right to get a copy of his/her information, make sure it is correct and know who has seen it.[5]

Perform Financial Clearance

Financial Obligations for Scheduled Services

This could also be called "financial pre-determination" or "financial clearance," as it is the method through which the provider identifies actual payment sources and assists the patient in determining expected reimbursement, their out-of-pocket expenses and alternative funding sources.

Since the ACA was implemented, more patients are faced with higher out-of-pocket cost in the form of deductibles and co-insurance. It is very important that the patient understand their financial obligation or their portion of the estimated bill prior to providing services. The more transparent the healthcare industry can become in their pricing, the more informed the patient can be, thus ensuring improved patient experience. This may also be a good time to collect the copays or ask for a deposit for larger out-of-pocket expenses. Some organizations automate propensity-to-pay solutions to determine a patient's ability to pay, equipping pre-arrival teams with the necessary information to appropriately engage financial counselors or offer charity applications at the earliest time possible.

[5]www.hhs.gov

Gathering and Entering Demographic Information

Demographic information is defined as patient identifying and contact information. Demographic information has both a clinical and financial purpose and must be accurate and complete.

Demographic information examples include:

- Legal name
- Date of birth
- Social Security number
- Address
- Telephone number
- Employer
- Employer contact information
- Emergency contact/next of kin

Demographic information is verified by obtaining positive identification of the patient in combination with a verbal interview of the patient or patient representative. Patient Access associates should conduct the interview by asking the patient to validate key data – do not ask by stating what is already listed in the system.

Verify Eligibility and Interpret Benefits

The first step is contacting the insurance company. This is important to verify eligibility, since they will tell us what services are covered and if the member is currently eligible. Insurance verification can be done in several ways – calling the individual payer directly, accessing a payer (or third party) website, or via integration with the registration system.

Once the type of visit is determined, you will be able to gather all necessary information for that particular plan. You must be aware of the type of plan it is (HMO, PPO, etc.). If you do not know, ask the insurance company when you call. Be sure to determine the following:

- Insurance eligibility
- Authorization requirement
- Pre-certification/pre-authorization
- Out-of-pocket maximum
- Deductible
- Co-payment
- Co-insurance
- Carve out
- Lifetime maximum
- Exclusions
- Verification of physician

The next step is to contact the patient. Inform them of their responsibility, as they do not want to be surprised at the time of service. Verify all demographic and insurance information is correct and ask for any out-of-pocket monies due.

Access representatives have a significant responsibility for the accurate collection and verification of insurance. They must know the questions to ask to obtain complete employment and insurance information.

Validate and Meet Payer Requirements

A patient may be covered under two or more insurance plans. Insurance can either be primary, secondary, tertiary, etc. Depending on several key factors – employment status, payer requirements, etc., a payer becomes secondary only if there are costs that the primary insurer didn't cover. Supplemental plans are always secondary to the primary payer. Medicaid is always the payer of last resort.

Secure Prior Authorization

Depending on the payer contract, certain CPTs require authorization prior to the patient receiving service. Each payer has different requirements depending on the contract and the type of facility/service type/location. Prior authorization is certification that the service (CPT) will (or will not) be covered by the payer; however, it does not guarantee payment, nor does it indicate that the patient is eligible — thus the importance of determining accurate eligibility first. If the procedure is not covered, it is considered denied and notification should be made back to the referring physician to obtain additional information, otherwise the patient could be responsible for the full charges if they choose to continue with the service. If an authorization is required and not secured prior to services being performed, the claim will receive a denial and potentially be written-off. In some cases, an appeal can be made to overturn the denial if there is supporting medical record documentation to support the test being performed — e.g., rad protocol changes where patient condition warranted additional tests while under sedation, etc.

Prior authorization can be done internally at the facility and sometimes is outsourced to a third-party service. Once the authorization is obtained, it is vital that the information be entered into the hospital's billing system to ensure the claim is not denied for no authorization.

Patient and Family Education

The goal of patient and family education is to plan, support and provide accurate, consistent, understandable information to patients and their family about their healthcare environment or treatment. Education provided to patients and families is based on an assessment of learning needs, abilities, preferences and readiness to learn. The assessment considers age, cultural and religious practices, emotional barriers, desire/motivation to learn, physical/cognitive limitations, language barriers and the financial impact of care choices. It is preferable to ask the patient and family how they learn best, i.e. visual, hands-on demonstration, etc. Evidence of the assessment is usually placed in the medical record.

All patients and their families should be provided with education and/or training as appropriate to:

- Increase knowledge of the patient's illness and treatment needs
- Learn skills that promote healthy behaviors, support recovery and accelerated return to baseline function
- Enable patients to be involved in decisions about their own care
- Specific prep instructions for the test/procedure they are scheduled for (e.g., blood work needed prior to test, fasting requirements, need to stop any medications prior to test, etc.)

Education can take many forms and can be as simple as how to navigate to the correct department for their procedure within the hospital or to the hospital or doctor's office on the day of the procedure, directions for parking, and drop-off and pick-up locations. Maps to local hotels and places to eat may be helpful to family members from out of town attending to a seriously ill family member.

Wayfinding

In small medical facilities, wayfinding may refer to a signage system that directs patients, family and visitors to their destinations. As medical facilities expand, the physical environment may be very complicated. Directions that seem self-evident to employees and people who are familiar with the facility may be confusing to others. Wayfinding also encompasses such issues as:

- Directions and alternate means of transportation to the facility
- Location of parking and patient drop-off points in relation to the location of the service area
- Campus maps
- Visual cues (such as color-coding and repetitive designs)

Wayfinding can be categorized as a:

- User experience: the experience of orienting and choosing a path, self-navigating through the surroundings, going from point-to-point along a predetermined route
- Process: the process of generating a design solution providing aids to assist the navigational process; tools often include maps/user guides, audible communication/written directions, tactile elements, consistent simplistic terminology and environment graphics
- Plan: the plan includes recognizing the human factor and bringing communication to the lowest common denominator, including provisions for users unfamiliar with their environment who are under stress and may have special needs, such as being visually impaired
- System: recognizing that the plan takes careful orchestration, preplanning and commitment

Effective wayfinding through a medical facility can help alleviate anxiety among patients and reduce strain on staff who are less likely to be needed to provide directions.

Wayfinding tools should be compliant with the ADA (Americans with Disabilities Act), The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other governing agencies and regulations.

One trend in wayfinding is interactive digital signage — the use of electronic kiosks and flat-panel screens that display instantly updated information. In a hospital setting, where patients and visitors are searching for department locations that may change frequently, this high-tech solution to provide easily updated information may be just what the doctor ordered.

Patient Access plays an important role in assisting in the development of a wayfinding plan, providing information and tools to patients and visitors, and in forwarding feedback from patients and visitors regarding the wayfinding tools.

Pre-Registration Practice Questions

See page 142 for answer key

1. What are the five data attributes of NAHAM's Best Practice Recommendations?
   - **a.** Patient name, date of birth, address(es), phone number(s), sex/gender
   - **b.** Patient name, date of birth, subscriber name, address(es), sex/gender
   - **c.** Patient name, address(es), phone number(s), insurance, sex/gender
   - **d.** Sex/gender, patient name, date of birth, next of kin, address(es)

2. What law gives the patient his/her right to the use of his/her medical information?
   - **a.** OIG
   - **b.** HIPAA
   - **c.** NAFTA
   - **d.** ACA

3. What steps are involved in the financial clearance process?
   - **a.** Verify demographics and insurance information are correct
   - **b.** Verify eligibility, determine prior authorization requirements
   - **c.** Calculate estimates and out-of-pocket cost
   - **d.** Qualify patient for discount or charity care, calculate propensity-to-pay score
   - **e.** All of the above

4. What is the first step to verifying eligibility?
   - **a.** Contacting the insurance company
   - **b.** Asking the patient
   - **c.** Copying the insurance card
   - **d.** Collecting the out-of-pocket due

5. What is COB?
   - **a.** Coordination of benefits
   - **b.** Couldn’t obtain benefits
   - **c.** Collection of benefits
   - **d.** Check on balance

6. What rule determines which plan will be primary for dependent children when both parents have the child insured under their plan?

   a. Spouse rule

   b. Benefit rule

   c. Birthday rule

   d. Rule of thumb

7. Prior authorization is:

   a. Certification that the service will be covered

   b. An action that does not guarantee payment

   c. A requirement that may vary depending on the contract with the insurance company

8. Why is patient experience important to a healthcare system?

   a. So the hospital does not get sued

   b. HCAHPS scores are affected by patient experience and can affect reimbursement if negative outcomes exist

   c. Physicians will not leave

9. The experience of orienting and choosing a path, self-navigating through the surroundings, going from point-to-point along a predetermined route is an example of _____?

   a. Wayfinding

   b. Centralized scheduling

   c. GPS

   d. Patient experience

10. What is one name for a comprehensive list of all patients and their key identifiers?

    a. Master Patient Index (MPI)

    b. Enterprise Master Person Index (EMPI)

    c. Corporate Person Index (CPI)

    d. All of the above

Arrival

PATIENT CHECK-IN, ADMISSION, REGISTRATION

Chapter Objectives

- Reviewing/validate patient order for type of service (e.g., inpatient, observation, outpatient, ED)
- Explain and execute patient registration forms (e.g., The Patient Bill of Rights and Responsibilities, HIPAA, consents, other required documents)
- Validate demographics, admission source, clinical and financial information
- Verify patient identification, order and insurance
- Validate ordered levels of care (e.g., ICU, PCU and telemetry)
- Indicate value of patient portal

Key Terms

- Patient class
- Patient registration forms
- Patient Rights and Responsibilities/Advance Directives and Durable Power of Attorney
- HIPAA
- Notice of Privacy Practices
- Consents
- Important Message from Medicare
- Medicare Secondary Payer Questionnaire
- Medicare Outpatient Observation Notice (MOON)
- Validation of Demographics
- Orders/levels of care
- Insurance

A Patient Access employee should always validate the patient order for treatment, to ensure that it is correct and that they are following the proper procedures for registration.

Patients who present to a healthcare organization may have orders for one of several different patient classes such as inpatient, outpatient, observation, emergent, etc. The patient class not only determines the level of care and the urgency of treatment, but it is also a factor in the registration process. Different classes require different forms and different procedures for registration.

Patient Registration Forms

Patients have certain rights and responsibilities during a healthcare encounter. In addition, patients have the right to file a complaint or grievance at any time during the healthcare encounter if they feel an unsatisfactory situation has arisen. Patient Rights and Responsibilities must be posted throughout the facility and many states require a written version also be available to the patient upon admission.

Patient Access employees should review the Patient Rights and Responsibilities information and be prepared to direct a patient to the appropriate department for questions or concerns. In addition, staff should acquaint themselves with the facility-specific complaint resolution and grievance process.

The Patient Self-Determination Act (PSDA) of 1990 affords patients the right to participate in their own healthcare decisions, including the right to receive or refuse treatment. State laws vary on recognized legal documents pertaining to Advanced Directives, Living Wills and Durable Power of Attorney for Healthcare. Some states may limit an individual's rights under certain circumstances, but none may prohibit the patient's right to participate in decision-making.

In the chart below, please see some of the information notices/forms patients will need to receive when coming for treatment.

INPATIENT	OUTPATIENT	OBSERVATION
• Patient Rights and Responsibilities • Advance Directive • Durable Power of Attorney • HIPAA • Notice of Privacy Practices • Consents • Important Message from Medicare	• Patient Rights and Responsibilities • Advance Directive • Durable Power of Attorney • HIPAA • Notice of Privacy Practices • Consents • Medicare Secondary Payer Questionnaire	• Patient Rights and Responsibilities • Advance Directive • Durable Power of Attorney • HIPAA • Notice of Privacy Practices • Consents • Medicare Secondary Payer Questionnaire

• Medicare Secondary Payer Questionnaire	• Medicare Outpatient Observation Notice (MOON)	• Medicare Outpatient Observation Notice (MOON)

Validating Demographic Information

When a patient checks in for a procedure, their demographic information should be validated. A review of the patient's demographic information should be completed at the time of either check-in, admission or registration, depending on the service. Patient identification (e.g., driver's license, passport or other government-issued form of identification) should be used to verify the patient's demographic information and their identity.

At the time the patient presents, the type of service should also be validated by checking the reservation for the procedure, the doctor's order if presented by the patient, or in the patient's medical record. The physician order should include the clinical reason for admission.

Insurance and Payment Information

Patient Access also obtains financial information from the patient and should be verified at the time the patient checks in and/or is registered. This information must be accurate and complete to ensure proper claims submission to the third-party payer and allow for collection of outstanding patient obligations prior to services and/or after the claim is processed. At the time the patient presents, the Patient Access employee should ask the patient for their insurance card and verify the insurance is active. Many patient registration systems can complete an insurance verification. In the case that insurance verification cannot be completed using the registration system, the Patient Access employee can also verify using the insurance company's website or by the Policyholder's employer.

Validate Ordered Levels of Care

Levels of care need to be validated, as they often drive what type of registration is completed in the patient registration system. The level of care a patient will receive is based on the physician order for what treatment the patient will be receiving.

Acute care – Medical attention given to patients with conditions of sudden onset that demand urgent attention or care of limited duration when the patient's health and wellness would deteriorate without treatment. The care is generally short-term rather than long-term or chronic care.

Acute Inpatient Care – A level of healthcare delivered to patients experiencing acute illness or trauma. Acute care is generally short-term (<30 days).

ICU – Intensive Care Unit. This is the most critical care unit for patients who are unstable or have a high potential of becoming unstable. Many of these patients require invasive monitoring, frequent medications, frequent vital sign recording, and/or ventilators to assist with breathing.

Step Down – A less critical care unit that is a "step down" from ICU. These patients may still require telemetry.

Med/Surg Floor – The most basic level of acute care. Typically, does not require frequent vital signs or telemetry.

***Note*: Not all patients stop at each of these units. Some may be discharged to home from a tele floor.**

Observation Care – Those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff. Services should be reasonable and necessary to evaluate the need for a possible admission to the hospital as an inpatient. Observation services usually do not exceed 24 to 48 hours. Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admission. Services not reasonable and necessary for the diagnosis or treatment of the patient, but provided for the convenience of the patient or physician, are considered an inappropriate use for this level of care.

Outpatient Care – Treatment received at a hospital, clinic or dispensary, but the patient is not hospitalized. Examples of outpatient (OP) services include:

Ancillary Services – Physician refers patients for scheduled and non-scheduled services such as radiology, laboratory, and/or other services that are performed in a hospital or clinic setting. Patients leave the facility once the services are completed.

Emergency Services – Patients examined on an unscheduled emergent basis for immediate treatment in the emergency facilities of a hospital. Depending on the outcome of the exam and treatment, the patient may be admitted as an observation patient, admitted to the facility as an inpatient or transferred to another facility as deemed necessary by the physician.

Ambulatory Services/Same Day Surgery – Patient receives surgical treatment and is discharged from the facility within four to six hours of procedure. Ambulatory services can occur in an outpatient hospital department or in a freestanding ambulatory care facility.

Specialty Clinics – Patient seen for specialized medical or surgical services and is discharged following treatment or care. This could be for a series of recurring visits based on the duration of care according to the physician's order.

Recurring Services – Physical therapy, occupational therapy, speech therapy, cardiac rehabilitation or pulmonary rehabilitation that occurs over time based on a clinician's order and evaluation by the clinical staff before and during the course of care.

Long-Term Care – Generally provided to the chronically ill or disabled in a nursing facility or rest home. Among the services provided by nursing facilities: 24-hour nursing care, rehabilitative services such as physical and occupational therapy and speech therapy, as well as assistance with activities of daily living. Coverage for nursing facility care is available under both the Medicare and Medicaid programs. Medicare beneficiaries are eligible for up to 100 days of skilled nursing or rehabilitative care. Medicaid coverage is available for those who have exhausted their own resources and require public assistance to help pay for their care.

Respite Care – Short-term care provided at home, in a long-term care facility, at a community-based center, or in a hospital when another setting is not available. Respite care allows families caring for elders or other mentally or physically dependent family members time off in their care-giving responsibilities. This type of care is not reimbursable through Medicare or Medicaid.

Hospice – A non-profit organization dedicated to patients and families facing serious illness or death. Hospice provides a support system to patients and families who choose to share their last days together in the comfort of their home or hospice designated facility. Hospice provides a wide range of services that include: coordination of care with the patient's primary care physician, skilled nursing visits, spiritual counseling and social worker support. The hospice staff are an interdisciplinary team who coordinate an individualized plan of care for each patient that is directed by the primary care physician. Hospice care is a covered service under the Medicare program.

Palliative Care – The medical specialty focused on relief of the pain, symptoms and stress of serious illness. The goal is to improve quality of life. Palliative care is appropriate at any point in an illness and can be provided at the same time as curative treatment.

Patient Portal

Many healthcare organizations utilize patient portals as a means for allowing patient's access to their electronic health record. These tools give patients a look into various data points, including lab results, physician notes, their

health histories, discharge summaries and immunizations. Patients who utilize these patient portals tend to be more engaged in their healthcare and the decisions surrounding their care. Additionally, patients who sign up to use a portal tend to be more proactive with their care and also be more loyal to the healthcare organization.

Patient Access employees should be familiar with their organization's patient portal and be able to explain the benefits of access to the patient. Finally, Patient Access employees should be able to explain the process for enrollment and assist the patient in enrolling if needed.

Patient Check-In, Admission, Registration Practice Questions

See page 143 for answer key

1. What type of service is not generally found on a patient order?
   - **a.** Inpatient
   - **b.** Ambulatory surgery
   - **c.** Observation
   - **d.** Maternity

2. Patients receive several forms/information notices during the check-in/registration process. Indicate the form they do not receive:
   - **a.** Patient Bill of Rights
   - **b.** Notice of Privacy Practices
   - **c.** Information on Advanced Directives
   - **d.** Procedural Consent Form

3. What form of identification should be used to verify patient identity?
   - **a.** Work badge
   - **b.** Insurance card
   - **c.** Driver's license
   - **d.** Social Security card

4. Why is it important to validate type of service when a patient checks in?
   - **a.** Drives the type of registration flow to be completed
   - **b.** The registrar can predict the length of stay for the patient
   - **c.** The Patient Access employee is making sure the physician order is correct

5. The physician order for treatment should include all of the following information, except:
   - **a.** Type of service
   - **b.** Level of care
   - **c.** Reason for visit (diagnosis)
   - **d.** Patient address

PATIENT AND FAMILY EXPERIENCE

Chapter Objectives

- Identify services to help reduce patient and family stress and increase customer satisfaction
- Indicate internal wayfinding (e.g., transport and facility signage)
- Identify relevant information to provide to patient and family (room number, visiting hours, etc.)
- Manage patient tracking (e.g., locating, transporting, routing)
- Recognize service recovery opportunities (e.g., validating parking and free meal tickets)

Key Terms

- Patient experience
- Continuum of care
- Patient Access associates
- Greeters
- Volunteers
- Kiosk
- Wayfinding
- HIPPA Privacy
- Financial Assistance Counselors
- ABN (Advance Beneficiary Notice)
- Charity Care
- Patient Escorts
- Doorkeeper
- Completed Pre-registration
- POSC
- JCAHO

What is Patient Experience?

Navigating through the healthcare system can be a daunting and often stressful experience for patients. After all, they are looking for answers. What is wrong with them? Has the doctor identified the right test or treatment? What will the test or treatment cost? How much of that cost will they be responsible for paying? If you were to ask a patient what they want in a positive patient experience, they will likely tell you that the least they expect from the hospital is excellent medical care. After all, that is why they chose a specific doctor or hospital. On further dialogue, they will likely focus on how helpful people were, how long they had to wait, how knowledgeable the staff seemed to be and, finally, what kind of specific help the staff provided them with those questions mentioned above and looming in the back of their mind.

Please read, for example, the following example of a definition for patient experience:

The Definition of Patient Experience

"The sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care."

-The Beryl Institute

There are many touchpoints upon arrival that will define what the patient feels was a good or bad patient experience for them. In each of these steps and processes, it is important that Patient Access associates (front-line, supervisory, volunteers and management) have a clear understanding and training on these steps and processes.

Front Desk and Greeters

Many hospitals have a central registration point where patients are asked to present. Typically, those directions are given by someone in Central Scheduling, but they may also be provided by employees who work in clinics, imaging, etc. By whatever means directions are provided, the directions need to be easy to understand and to navigate. When the patient presents to the facility, they either check in with the front desk staff or, in some cases, are directed to a self-check-in kiosk or maybe a touch screen monitor. Front desk staff and volunteers must be prepared to:

- Courteously greet all patients/visitors/family
- Assist the patient with getting signed in or checked in. HIPPA privacy changes have impacted the way patients are being checked in. Most hospitals have dispensed with the use of sign-in sheets, as they do not provide privacy.
- Record the time of the patient's arrival in the lobby and also later in the registration booth.
- Provide the patients with directions to seating, restrooms, etc.

Registration Booth

Arrival tracking boards or software are often used to identify which patients have arrived for their day of service. Care should be taken to give preference to those patients who have been cooperative with the hospital and completed pre-registration processes. Whenever possible, these patients should be fast-tracked and moved expeditiously onto their test area. Typically, a "completed" pre-registration patient need only to pay their point of service collections (POSC) amounts, sign forms, get an arm band and exit for service. NAHAM has developed the Pre-Registration Process Tiers as a national standard for Patient Access. These process tiers define and qualify a true completed pre-registration. When accomplished, this critical work provides the registrar the ability to fast-

track the patient, therefore providing a better customer experience. Below, see an example of the tiers; you can access all tiers and more information in the NAHAM AccessKeys.

Key services provided by the registrar in the booth may include:

- Obtaining all accurate demographic, employment, guarantor and insurance data used to help create a chart and set up the account for billing and payments.
- Obtaining insurance eligibility responses to determine if insurance will cover the service and also to determine what portion the patient will need to pay.
- Obtaining insurance authorizations for the service being provided.
- Providing Advance Beneficiary Notice (ABN) in the event a service is deemed not covered by insurance and yet the patient has opted to still have the service; the ABN notice will allow the hospital to bill the patient and get paid for the service.
- Providing the patient with payment options and taking their payment.
- Performing in the role of Financial Assistance Counselors; this will involve advising the patient of ways to take care of their portion of the hospital charges.
- Depending on the hospital's processes, the registrar may also work with the patients who may qualify for Charity Care assistance.

Financial Assistance Counselors

Is front-end patient financial counseling a part of or a contributor to a positive patient experience; if so, how? Yes, it is imperative that healthcare providers make this service easily accessible and friendly. Many hospital providers have financial counselors located near or in the registration site. Depending on the workflow or process established, the counselor may get patients referred to them by the registrars who need financial assistance before they have the service. In some situations, the hospital's policy is to let the patient have the service and then be directed back to the office of the financial counselor.

Many hospitals have established financial counselors in the Emergency Department. Patients who have completed their ED treatment and are discharged to home will be referred to the discharge check-out area. Registrars in this area are trained to ask for POS dollars and to offer payment plans and assistance.

Volunteers and Patient Escorts:

While it may vary with hospitals, many have volunteer or patient escorts to assist patients in various ways. The goal is to help relieve stress for the patient and improve their experience. Volunteers or patient escorts can provide the following helpful services:

- Provide simple and easy directions to service areas
- Assist patients who seem to be lost by offering to call service areas to see if they are expecting the patient and at what time
- Physically escorting patients to service areas, particularly those departments that are hard to find or may be located in another building or section
- When appropriate, offering the patient refreshments or nourishment, making sure that doing so will not interfere with testing

Positive Patient Experience

As previously mentioned, patients may see hospitals as confusing, hard to navigate and difficult just to understand how things work. Healthcare workers, on the other hand, see the hospital in a different light simply because they are there on a daily basis. Healthcare employees have already learned how to find their way around and have learned about most of the hospital's rules and policies. This applies to Patient Access personnel. They are best positioned to be able to help patients, families and visitors get through the experience with less problems and in less time.

Hospitals are always looking for better ways to provide assistance to customers. Below are some of the concierge services Patient Access personnel could be involved in to assist patients as the "doorkeeper," somewhat like hotels:

- Providing call back via the use of restaurant pagers. Often, these pagers are provided to patients who are awaiting their turn in high-volume centers.
- Pagers may also be provided to family members who are waiting while a loved one has a procedure or surgery. The pager provides a communications link for the family who need to leave for food or other personal business.
- Valet parking is an extremely helpful service to patients and family. It reduces the stress of trying to find a parking space or navigate through a parking garage.
- Complimentary meals or meal tickets are a nice way to help families who may have long waits at the facility. Included in this service may also be coupons for coffee or snacks in the gift shop or cafeteria.
- Access to complimentary guest WiFi is also a service in today's high-tech world that can prove to be helpful to customers.
- Assistance with kiosks and check-in applications/equipment.

Should We Measure the Success of Registration's Impact on the Patient Experience?

The answer to that question is *yes*, and NAHAM has provided those key performance indicators (KPIs) and a target program for implementing the use of these KPIs. It is recommended that hospital Patient Access personnel start with the top three they want to implement. Once they have successfully implemented those top ones, then move on to the next ones. It is important to see success and to see all staff fully adopting this important objective.

Employees in Patient Access, no matter their assigned job, need to know how they are performing. If you were to ask an employee in Admissions or ER if it is important to them to know how they are perceived and how they are performing, they would say "yes." However, to take it a step further, they would want to know how they will be measured, is it fair, and is the same rule or policy applied fairly. This is where KPIs come into play. It has only been a short period of time since Patient Access professionals have established national KPIs. However, these KPIs have become the professional gold standard in setting guidelines for improvements, measuring performance and monitoring successes.

NAHAM has provided a list of all AccessKeys for its members at NAHAM.org.

While all NAHAM KPIs have a direct impact and connection to improving patient experience, these are a few that stand out:

PX-1	Pt Experience	Patient Access Experience Rate	Total Survey Scores / Surveys Completed	3.5 to 3.9	4 to 4.5	>4.5
PX-2	Pt Experience	Average Wait Time	Total Minutes Spent Waiting / Total Registrations	15 mins	10 mins	5 mins
PX-3	Pt Experience	Average Reg Time	Total Minutes in Registration / Total Registrations	10 Mins	7 Mins	5 Mins
PX-4	Pt Experience	Average Pre-Reg Call Time	Total Pre-Reg Call Time / Completed Pre-Registrations	10 Mins	7 Mins	5 Mins
PX-5	Pt Experience	No Show Rate	No-shows / Scheduled Patients	5%	3%	1%
PX-6	Pt Experience	Left Without Being Seen Rate	LWBS Patients / ED Registrations	5%	3%	1%
PX-7	Pt Experience	Call Abandonment Rate	Abandoned Calls / Total Patient Calls Received	7%	5%	3%
PX-8	Pt Experience	Speed to Answer Rate	Calls Answered <30 seconds / Total Patient Calls	70%	80%	90%

Do POSC collections processes impact patient experience? It has become a normal way of life and business in hospitals to attempt to collect prior to service. Through education, sound policies and various marketing campaigns, hospitals have been getting the word out. The idea is to support patients in this area of their lives that can be extremely stressful. We do this by being transparent about the cost of care, informing patients of what their insurance provider will pay, and what they will be required to pay. Patients do not like going to their mailboxes and getting hit with an unexpected bill. To counter this and to provide better service and experience, hospitals need to

inform patients prior to the service about their portion of the cost of care. This should be viewed as a service that does impact the patient's experience. When a patient is better informed and able to be involved in decisions about medical expenses, they will be more likely to cooperate.

What Are Some Key Staff Behaviors Impacting Patient Experience?

Compassion is as significant as competence in creating a positive healthcare experience. People really do want to feel that the hospital cares about them and that they are not just a number on a clipboard. Getting too technical or over the head of the patient will just add to their confusion.

A common sense approach is more useful in patient relations. Engaging in the following behaviors, healthcare employees can create a positive impression:

- Smile, make eye contact and call patients by their preferred name.
- Allow visitors and patients to enter the elevator first to demonstrate respect and compassion.
- Take time to explain procedures, guidelines and why things are happening, and offer help when someone looks confused, which helps reduce stress.
- Personal cell phones are a huge turnoff to patients; staff should have theirs out of sight.
- Limiting conversations in hallways and elevators and other public areas aids in assuring privacy.
- Accepting responsibility for problem resolution and providing service recovery is a must.
- A professional appearance demonstrates competence, so abide by department dress codes.
- Navigating through a large facility can be confusing for our patients. Be willing to escort them to their destination. This is especially helpful to the elderly or confused patient.

What Are Some Relevant Information or Resources to Be Provided to Patients?

- Patients' Bill of Rights should be displayed in the department and provided to all patients who request it. Having copies readily available shows good service.
- Financial policies such as prompt pay discounts should be readily available to share with patients. This will demonstrate staff's knowledge regarding financial assistance policies.
- Be prepared to offer assistance to patients in the event of a fire or fire drill. The Department of Health and Environmental Control (DHEC) is the regulatory agency overseeing the hospital's compliance with patient safety.
- Provide hand sanitizer and face masks to patients needing them. This is important during cold and flu season.
- Provide visitation hours, directions to nursing units, service areas, cafeteria, etc., all shows the

willingness to make things easier for the patient and family.

- Do not try to provide clinical instructions you are not sure of; consult with or go find a clinical practitioner to help explain needed information to the patient.

Assist with Internal Wayfinding

Patients and family members find healthcare facilities confusing and hard to navigate and find their way around. They often get lost, and this leads to frustration. Healthcare workers should never assume patients are familiar with how to find their way. It is better to ask if they need help. Wayfinding systems vary from large overhead signage to directional floor signage. Even so, it does not take the place of providing patients with simple instruction on how to get to Radiology, for example. It may also help to say “X-ray,” as some people may not understand “Imaging” or “Radiology.” It is all about using a common sense approach. Effective wayfinding through a medical facility can help alleviate anxiety among patients and reduce strain on staff who are less likely to be needed to provide directions.

Wayfinding also encompasses service to be helpful to patients such as:

- Printed maps with easy-to-follow directions
- Detailed, color-coded campus maps for large teaching facilities
- Transportation assistance, such as golf cart rides to a location
- Wheelchair assistance my need to be given directly or ordered through a central patient transport department
- Assistance with luggage for patients staying overnight
- Location of nearest parking lots
- Parking fees, if appropriate
- Patient discharge or drop-off instructions

While most hospitals are now smoke-free, patients will still want to know where they are allowed to smoke by policy.

Trends in Wayfinding

One trend in wayfinding is interactive digital signage — the use of electronic kiosks and flat-panel screens that display instantly updated information. In a hospital setting, where patients and visitors are searching for department locations that may change frequently, this high-tech solution to provide easily updated information may be just what the doctor ordered.

Patient Access plays an important role in assisting in the development of a wayfinding plan, providing information and tools to patients and visitors, and in forwarding feedback from patients and visitors regarding the wayfinding tools.

Manage Patient Tracking

Documenting the arrival and departure times allows caregivers to know where a patient is at any point of service during an encounter. What began in a traditional hospital environment as patient tracking and bed cleaning has expanded greatly in the current healthcare environment. Extended services, often involving many physical locations within a healthcare organization, make it more challenging and yet more important to be aware of a patient's current location.

Healthcare professionals understand that determining room availability, knowing if a patient has recently been treated, and monitoring a patient's total time in care are important but difficult tasks in a busy healthcare organization.

Because patient safety is compromised when there is high occupancy and overcrowding, The Joint Commission has included the management of patient tracking and patient flow in their requirements as well. Specifically, JCAHO LD 3.15 states "leaders develop and implement plans to identify and mitigate impediments to efficient patient flow throughout the hospital." The Joint Commission further requires that hospitals "must look at data and use data to make changes, and must have a patient flow committee."

Hospitals further understand that transportation is an important aspect of patient tracking and patient flow. Whether patients are being taken for a procedure, being transferred to another unit or needing assistance during discharge, efficient transportation is vital to ensure optimal patient tracking and patient flow. Not only is transportation important to patient tracking and patient flow, it is also a point of contact for over 30 percent of inpatients and an opportunity to make a positive impression.

Patient flow is often delayed when a wheelchair or stretcher cannot be located. Both patients and staff wait while transporters scramble to find the necessary equipment, creating a patient flow bottleneck that can easily escalate to affect numerous departments, clinical staff and patient wait times. With the use of hospital asset tracking on wheelchairs and stretchers, transporters are able to complete additional daily patient transports and reduce the number of excessive delays associated with patient transport.

There are various tools to assist in the process of tracking patient flow and equipment. Some facilities utilize Radio Frequency Identification (RFID) technology to support these processes. RFID is a system that transmits the identity of any object or person (in the form of a unique serial number) wirelessly using radio waves. More healthcare organizations are considering RFID for its potential to improve patient safety and business processes. RFID applications in the healthcare industry are focused on patient safety (identification and medication administration), business flow management and asset/equipment management.

Patient and Family Experience Practice Questions

See page 143 for answer key

1. What is the number one expectation of patients presenting for care at hospitals?
   - **a.** Help with finding their way around
   - **b.** Parking instructions
   - **c.** Excellent medical care

2. Patients use the following measures to grade or judge their patient experience, except:
   - **a.** How helpful staff are
   - **b.** How long they had to wait
   - **c.** Knowledgeable staff
   - **d.** How long it took them to get to the hospital

3. Is it a good practice to fast-track patients?
   - **a.** No, we need to interview every patient who comes in the door.
   - **b.** Yes, but only those patients who are coming in for laboratory work.
   - **c.** Yes, as long as all information is obtained from the patient.

4. The following are doorkeeper services that may be provided in Patient Access, except:
   - **a.** Wayfinding
   - **b.** Valet parking
   - **c.** Arrival check-in
   - **d.** Pet sitting

5. When should hospitals inform patients of the cost of care and their liability?
   - **a.** Upon discharge
   - **b.** In the service area, like the lab
   - **c.** Prior to receiving services

6. Should hospitals provide financial assistance to patients?
   - **a.** Yes, all patients should receive assistance
   - **b.** Yes, to those patients who meet criteria for assistance
   - **c.** No patient should receive assistance

BED MANAGEMENT

Chapter Objectives

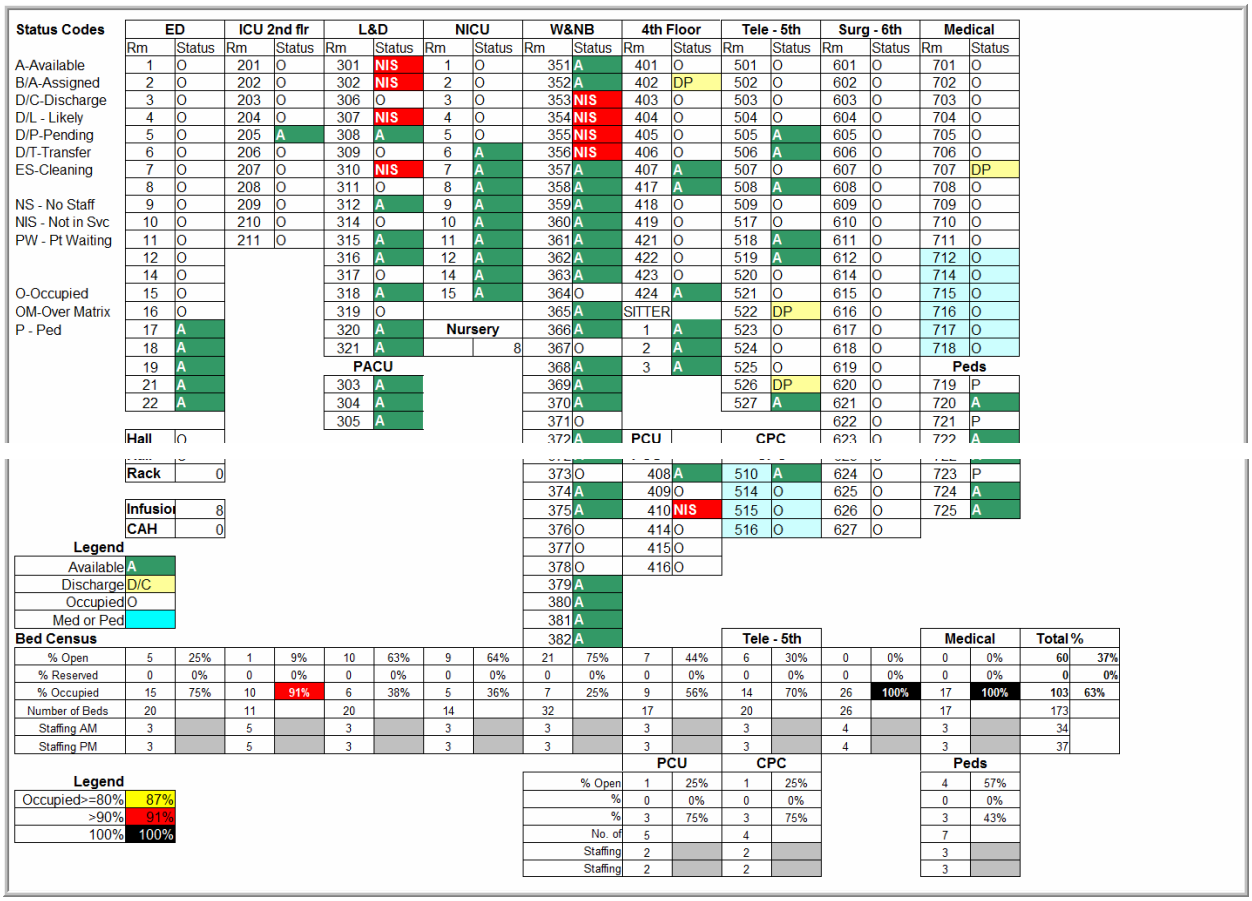
- Knowledge of information concerning patient placement
- Validate patient status change orders (e.g., observation to in-patient)
- Collaborate with case management (e.g., status changes)

Key Terms

- Level of Service
- Patient Placement
- Case Management

Knowledge of Information Concerning Patient Placement

The process of providing the most appropriate location and level of service is necessary for optimum clinical care delivery to the patient. In many hospitals, this process is referred to as bed control/management. Patient placement includes a request for a bed (inpatient, outpatient, observation, etc.). It involves the collection and documentation of the information necessary to determine that the requirements for the requested level of service are met. Requirements may include: isolation, telemetry needs, special observation etc. When the request has been determined to be appropriate and the requested level for service is available, arrangements are made to assure the patient's timely arrival. This may include transportation arrangements. Patient placement involves a close working relationship with nursing units but requires a central philosophy to maximize the utilization of resources. Many organizations utilize a bed management system to assist in patient placement, as seen here:



Status Codes	ED		ICU 2nd flr		L&D		NICU		W&NB		4th Floor		Tele - 5th		Surg - 6th		Medical	
	Rm	Status	Rm	Status	Rm	Status	Rm	Status	Rm	Status	Rm	Status	Rm	Status	Rm	Status	Rm	Status
A-Available	1	O	201	O	301	NIS	1	O	351	A	401	O	501	O	601	O	701	O
B/A-Assigned	2	O	202	O	302	NIS	2	O	352	A	402	DP	502	O	602	O	702	O
D/C-Discharge	3	O	203	O	306	O	3	O	353	NIS	403	O	503	O	603	O	703	O
D/L - Likely	4	O	204	O	307	NIS	4	O	354	NIS	404	O	504	O	604	O	704	O
D/P-Pending	5	O	205	A	308	A	5	O	355	NIS	405	O	505	A	605	O	705	O
D/T-Transfer	6	O	206	O	309	O	6	A	356	NIS	406	O	506	A	606	O	706	O
ES-Cleaning	7	O	207	O	310	NIS	7	A	357	A	407	A	507	O	607	O	707	DP
	8	O	208	O	311	O	8	A	358	A	417	A	508	A	608	O	708	O
NS - No Staff	9	O	209	O	312	A	9	A	359	A	418	O	509	O	609	O	709	O
NIS - Not in Svc	10	O	210	O	314	O	10	A	360	A	419	O	517	O	610	O	710	O
PW - Pt Waiting	11	O	211	O	315	A	11	A	361	A	421	O	518	A	611	O	711	O
	12	O			316	A	12	A	362	A	422	O	519	A	612	O	712	O
	14	O			317	O	14	A	363	A	423	O	520	O	614	O	714	O
O-Occupied	15	O			318	A	15	A	364	O	424	A	521	O	615	O	715	O
OM-Over Matrix	16	O			319	O			365	A	SITTER		522	DP	616	O	716	O
P - Ped	17	A			320	A	Nursery		366	A	1	A	523	O	617	O	717	O
	18	A			321	A		8	367	O	2	A	524	O	618	O	718	O
	19	A			PACU				368	A	3	A	525	O	619	O	Peds	
	21	A			303	A			369	A			526	DP	620	O	719	P
	22	A			304	A			370	A			527	A	621	O	720	A
					305	A			371	O					622	O	721	P
	Hall	O							372	A	PCU		CPC		623	O	722	A
	Rack	0							373	O	408	A	510	A	624	O	723	P
									374	A	409	O	514	O	625	O	724	A
	Infusio	8							375	A	410	NIS	515	O	626	O	725	A
	CAH	0							376	O	414	O	516	O	627	O		
Legend									377	O	415	O						
Available	A								378	O	416	O						
Discharge	D/C								379	A								
Occupied	O								380	A								
Med or Ped									381	A								
Bed Census									382	A			Tele - 5th				Medical	

																			Total %	
% Open	5	25%	1	9%	10	63%	9	64%	21	75%	7	44%	6	30%	0	0%	0	0%	60	37%
% Reserved	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
% Occupied	15	75%	10	91%	6	38%	5	36%	7	25%	9	56%	14	70%	26	100%	17	100%	103	63%
Number of Beds	20		11		20		14		32		17		20		26		17		173	
Staffing AM	3		5		3		3		3		3		3		4		3		34	
Staffing PM	3		5		3		3		3		3		3		4		3		37	

Legend	
Occupied>=80%	87%
>90%	91%
100%	100%

	PCU		CPC		Peds	
% Open	1	25%	1	25%	4	57%
%	0	0%	0	0%	0	0%
%	3	75%	3	75%	3	43%
No. of	5		4		7	
Staffing	2		2		3	
Staffing	2		2		3	

Infection Control

An important consideration in assigning the appropriate bed is infection control. In acute care hospitals, patients who require contact precautions should be placed in a single patient (private) room when available. When a single-patient room is not available, patients with the same MRSA should be placed in the same room or patient care area.

Various factors are important in determining the risk of transmitting infection and the need for a single-patient (private) room is best determined on a case-by-case basis. It may be necessary to consult with infection control personnel to obtain information regarding patient placement options. Methicillin-resistant Staphylococcus aureus (MRSA) is a type of bacteria that is resistant to certain antibiotics. Staph infections, including MRSA, occur most frequently among persons in hospitals and healthcare facilities (such as nursing homes and dialysis centers) who have weakened immune systems.

Validate Patient Status Change Orders

Validating a change in patient status requires a physician order. Status changes can occur when a patient moves from a lower level of care to a higher level of care (e.g., ICU to floor). The physician's order must be written for level of care and patient placement requirements.

Collaborate with Case Management

Coordination of services helps meet a patient's healthcare needs, usually when the patient has a condition that requires multiple services from multiple providers.

It is a process of identifying plan members with special healthcare needs, developing a healthcare strategy that meets those needs, and coordinating and monitoring the care, with the ultimate goal of achieving the optimum healthcare outcome in an efficient and cost-effective manner. Case management is intended to ensure continuity of services and accessibility to overcome rigid, fragmented services and the mis-utilization of facilities and resources. It also attempts to match the appropriated intensity of services with the patient's needs over time.

Bed Management Practice Questions

See page 143 for answer key

1. Which item is required to validate a change in patient status from one level of care to another?
   - **a.** An appropriate bed
   - **b.** A physician's order
   - **c.** Permission from nursing
   - **d.** Consent from the patient

2. What are the two key components in bed management?
   - **a.** Appropriate location and level of service
   - **b.** Valid insurance and correct registration
   - **c.** Isolation status and observation level
   - **d.** Bed availability and bed type

3. Which department can assist bed placement in determining appropriate level of service?
   - **a.** Nursing
   - **b.** Emergency Department
   - **c.** Social Work
   - **d.** Case Management

APPENDIX: GLOSSARY OF TERMS

Accreditation	Defined as “a self-assessment and external peer assessment process used by healthcare organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.”
Acute care	Medical attention given to patients with conditions of sudden onset that demand urgent attention or care of limited duration when the patient’s health and wellness would deteriorate without treatment. The care is generally short-term rather than long-term or chronic care.
Acute Inpatient Care	A level of healthcare delivered to patients experiencing acute illness or trauma. Acute care is generally short-term (<30 days).
Advance Beneficiary Notice (ABN)	Written notice issued to a fee-for-service (Original Medicare) beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity.
Advance Directive	Also known as a medical directive, healthcare directive or a living will, a legal document in which a person has outlined what they would like to be done if they are no longer able to make decisions for themselves due to incapacity or illness.
Ambulatory Services/Same-Day Surgery	Patient receives surgical treatment and is discharged from the facility within four to six hours of procedure. Ambulatory services can occur in an outpatient hospital department or in a freestanding ambulatory care facility.
Ancillary Services	Physician refers patients for scheduled and non-scheduled services such as radiology, laboratory, and/or other services that are performed in a

	hospital or clinic setting. Patients leave the facility once the services are completed.
Anti-Kickback Statute	Anti-fraud federal criminal statute that prohibits offering or exchange of anything of value in exchange for healthcare business referrals, including cash, rent, expensive hotel stays, etc.
Authorization Requirement	Certain services need authorizations while other procedures might not. Some insurance companies require a CPT code, so make sure you have that available.
Batch Processing	Execution of a series of jobs in a computer program without manual intervention; it is used to help maximize the use of computer resources and stabilize response time by performing system-intensive work during hours when users are less likely to require access. Unlike real-time transactions, jobs executed in batch are not available for users to view until after the batch is run.
Carve Out	A decision to separately purchase a service, which is typically a part of an indemnity of an HMO plan. For example, an HMO may “carve out” the behavioral health benefits and select a specialized vendor to supply these services on a stand-alone basis. Carve outs may also include medical devices that the plan pays for in addition to the contracted per diem or case rate. Pre-certification/pre-authorization is often required for these benefits and services.
Case Management	Coordination of services to help meet a patient's healthcare needs.
Centers for Medicare and Medicaid	Federal agency under the Department of Health and Humans Services (HHS) that administers Medicare and partners with state governments for

Services (CMS):	administration of Medicaid and other programs, including the Children's Health Insurance Program (CHIP).
CHAMPVA	The Civilian Health and Medical Program for the Veterans Administration is an insurance program for the families of veterans.
Charity care	Free or discounted medical care provided to patients who do not have the ability to pay for all or a part of medical costs due to limited income or financial hardship.
Co-insurance	The percentage amount that is payable, per policy provisions, toward medical costs after the deductible has been met. For example, a patient's coinsurance amount may be 20 percent, and the insurance company's coinsurance could be 80 percent under a contract.
Condition code 44	Sometimes a Medicare patient is admitted to a hospital as an inpatient but, upon internal review, the hospital determines the services did not meet inpatient criteria and the admission is changed to observation. This rule has become informally known as "condition code 44."
Co-payment	A payment that must be made by a covered person at the time of service. Services that require a co-pay, and the predetermined amount payable for each service, are specified in the policy. Co-payments may be required for physician visits, prescriptions or hospital services.
Electronic protected health information (ePHI)	Any protected health information (PHI) as identified under HIPAA that is produced, saved, received or transferred in an electronic format.

Deductible	The amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will begin to pay for eligible benefits.
DNV-GL Accreditation	DNV Healthcare is an accreditation organization approved by CMS in 2008 that has accredited approximately 500 hospitals.
Downtime	Time the computer system is unavailable to users.
Electronic health record (EHR)	A real-time, digitized version of a patient's medical history that allows secure information access to authorized users. Standard clinical and medical data is gathered by a provider and stored in electronic files. EHR goes beyond a single provider and can contain shared information from multiple providers to develop a comprehensive patient history.
Emergency Medical Treatment and Labor Act (EMTALA)	"Anti-Dumping" statute. Federal law protecting patients against discrimination regardless of ability to pay; mandates patients receive a medical screening exam and stabilizing treatment when seeking emergency medical care or when in active labor.
Emergency Services	Patients examined on an unscheduled emergent basis for immediate treatment in the emergency facilities of a hospital. Depending on the outcome of the exam and treatment, the patient may be admitted as an observation patient, admitted to the facility as an inpatient, or transferred to another facility as deemed necessary by the physician.
Ethnicity	A social group that shares a common and distinctive culture, religion, language or the like.

Exclusions	Certain procedures are excluded from the plan. Asking the insurance company will let you know what services are *not* included and covered in the plan.
Fair Debt Collection Practices Act (FDCPA)	Federal law prohibiting debt collectors from using unfair, abusive or deceptive practices while attempting to collect from a consumer.
False Claims Act	Federal law targets fraud against the government. “Whistleblower’s”/qui tam provision allows non-government individuals to “blow the whistle” in good faith on fraud against the government who may receive up to 30 percent of any recovered damages.
HCAHPS	Also known as Hospital CAHPS, it stands for Hospital Consumer Assessment of Healthcare Providers and Systems and is a standardized survey of hospital patients that will capture patients’ unique perspectives on hospital care for the purpose of providing the public with comparable information on hospital quality.
Health Exchange	Health Insurance Marketplace or “Exchange” — organizations that facilitate structured and competitive markets for purchasing health coverage.
Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)	Federal law stimulating the adoption of electronic health records and providing financial incentives for demonstrating meaningful use; also expanded HIPAA security and privacy rules and increased penalties; established data breach notification rules.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Originally focused on regulations related to health insurance portability; focused on administration simplification and reduction of cost through the protection and standardization of electronic and financial records. Most known for the privacy rule and security rule, these rules defined standards for healthcare and protected healthcare information (PHI).
Healthcare Facilities Accreditation Program (HFAP)	An accrediting organization tied to Medicare Conditions of Participation Coverages.
HITECH Omnibus of 2013	This update to the HITECH Act revised provisions that focused on an individual's right to request restrictions on the disclosure of PHI (restricted disclosure) and on an individual's right to access his or her PHI stored in an EHR.
Hospice	A non-profit organization dedicated to patients and families facing serious illness or death. Hospice provides a support system to patients and families who choose to share their last days together in the comfort of their home or hospice designated facility. Hospice provides a wide range of services that include: coordination of care with the patient's primary care physician, skilled nursing visits, spiritual counseling and social worker support. The hospice staff are an interdisciplinary team who coordinate an individualized plan of care for each patient that is directed by the Primary Care Physician. Hospice care is a covered service under the Medicare program.
Icon	A graphic symbol for an application, file or folder.
Important Message from Medicare (IMM)	IMM is a form given to all Medicare beneficiaries who are inpatients in participating hospitals explaining their rights and what to do if they feel they are being discharged early.

Insurance eligibility	The person entitled to benefits and is covered. The date they became eligible for the plan is important to know since information can change from month to month along with the termination date of coverage.
Level of Service	The type of care a patient need for their stay. There are three levels of service: Intensive Care (ICU), step down, floor, observation and outpatient.
Lifetime Maximum	What is their lifetime maximum? Many payers have a calendar year and a lifetime maximum limit on benefits paid. Once the maximum has been reached, the benefits have been exhausted. There are no more funds available for coverage of any further services.
Living Will	See advance directive
Long Term Care	Generally provided to the chronically ill or disabled in a nursing facility or rest home. Among the services provided by nursing facilities: 24-hour nursing care, rehabilitative services such as physical and occupational therapy and speech therapy, as well as assistance with activities of daily living. Coverage for nursing facility care is available under both the Medicare and Medicaid programs. Medicare beneficiaries are eligible for up to 100 days of skilled nursing or rehabilitative care. Medicaid coverage is available for those who have exhausted their own resources and require public assistance to help pay for their care.
Meaningful Use (MU)	An incentive program established to provide monetary incentives for the adoption and meaningful use of health information technology and qualified electronic health records.

Medicaid	Medicare covers low-income adults, children, pregnant women, elderly adults and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States.
Medically necessary	According to Medicare.gov, “medically necessary” is defined as “healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.”
Medicare Administrative Contractor (MAC)	A private healthcare insurer that has been awarded a geographic jurisdiction to process Medicare Part A and Part B medical claims for Medicare Original beneficiaries.
Medicare Outpatient	Observation Notice (MOON): A form given to Medicare beneficiaries to inform them of their outpatient observation status and to explain to them what that may mean financially.
Medicare Savings Programs	A program in which Medicaid pays Medicare premiums, deductibles and/or coinsurance costs for beneficiaries eligible for both programs. When a patient has this program, they are referred to as being dual eligible.
Medicare Secondary Payer (MSP) questionnaire	Medicare-required questions to determine if there are any other payers or situations that may pay primary to Medicare.
Medicare Two-Midnight Rule	CMS rule stating that for a hospital admission to be paid for under Medicare Part A, the patient stay had to cross two midnights. Anything less than two midnights is paid for under Medicare Part B.

Minimum Necessary Standard	Concept that people should only access, use or disclose the health information that is minimally necessary to accomplish a given task or purpose.
Modified Adjusted Gross Income (MAGI)	Methodology established by The Affordable Care Act to determine income eligibility based on taxable income and tax filing relationships.
Network	A group of two or more computer systems linked together; variations include Wide Area Network (WAN), which is more extensive than a Local Area Network (LAN), which is not publicly accessible to a greater internet. A Hot Spot is a wireless LAN that provides internet access from a given location.
Observation Care	Those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff. Services should be reasonable and necessary to evaluate the need for a possible admission to the hospital as an inpatient. Observation services usually do not exceed 24 to 48 hours. Hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admission. Services not reasonable and necessary for the diagnosis or treatment of the patient, but provided for the convenience of the patient or physician, are considered an inappropriate use for this level of care.
Out of Pocket Maximum	The total payments toward eligible expenses that a covered person funds for him/herself and/or dependents. These expenses may include deductibles, co-pays and coinsurance as defined by the contract. Once this limit is reached, benefits will increase to 100 percent for health services received during the rest of that calendar or policy year. Deductibles may or may not be included in out-of-pocket limits.
Outpatient Care	Treatment received at a hospital, clinic or dispensary, but the patient is not hospitalized. Examples of outpatient (OP) services include: ancillary services, emergency services, ambulatory services/same-day surgery,

	specialty clinics, recurring services, long-term care, respite care, and hospice and palliative care.
Palliative Care	The medical specialty focused on relief of the pain, symptoms and stress of serious illness. The goal is to improve quality of life. Palliative care is appropriate at any point in an illness and can be provided at the same time as curative treatment.
Patient Contact Center	A central point in an organization from which all customer contacts are managed, including scheduling, pre-registration, pre-verification, prior authorization, functions, etc.
Patient Experience	The outcome of interactions between an organization and a customer as perceived through the customer's conscious and subconscious mind. It is especially important in determining HCAHPS reimbursement.
Patient Placement	Includes a request for a bed (inpatient, outpatient, observation, etc.). It involves the collection and documentation of the information necessary to determine that the requirements for the requested level of service are met.
Patient Portal	Secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an internet connection. Some portals allow for viewing recent hospital visits or the ability for a patient to self-schedule certain tests to be performed at the hospital.
Patient Satisfaction	In evaluations of healthcare quality, patient satisfaction is a performance indicator measured in a self-report study and a specific type of customer satisfaction metric.
Personally identifiable information (PII)	Any type of information that can be used to identify a person such as name, Social Security number and medical record numbers.

Power of attorney	Type of living will; this document authorizes a specific person to make decisions on their behalf when they have become incapacitated.
Pre-certification/Pre-authorization	Certain insurance companies require pre-certification or pre-authorization from the Primary Care Physician (PCP) prior to services being performed.
Presumptive Eligibility	Hospitals and qualified physicians have the option of screening patients to see if they qualify for Medicaid. Based on the patient's self-attested answers to specific questions, they may be granted this temporary coverage but must complete the application process in order to keep the coverage.
Pricing Transparency	In healthcare, readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare and choose providers that offer the desired level of value.
Propensity to Pay	A means to evaluate payment risk, determine the most appropriate collection policy and initiate financial counseling discussions. Based on a scoring algorithm, programs can predict likelihood of payment. Those with a history of bad debt can be adjusted or forwarded to collections at the earliest point possible.
Protected health information (PHI)	Any protected health information (PHI), as identified under HIPAA, that is produced, saved, received or transferred.
Recovery	Process of restoring data that has been accidently lost, corrupted or made unavailable, typically from an external storage system used for back-up.
Recurring Services	Physical therapy, occupational therapy, speech therapy, cardiac rehabilitation or pulmonary rehabilitation that occurs over time based on a

	clinician's order and evaluation by the clinical staff before and during the course of care.
Respite Care	Short-term care provided at home, in a long-term care facility, at a community based center, or in a hospital when another setting is not available. Respite care allows families caring for elders or other mentally or physically dependent family members time off in their care-giving responsibilities. This type of care is not reimbursable through Medicare or Medicaid.
Restricted Disclosure	Defined in the HITECH Omnibus of 2013, a patient's right to restrict PHI disclosure.
Server	A central computer dedicated to sending and receiving data from other computers on a network.
Specialty Clinics	A patient is seen for specialized medical or surgical services and is discharged following treatment or care. This could be for a series of recurring visits based on the duration of care according to the physician's order.
Telephone Consumer Protection Act (TCPA):	A federal law regulating the use of prerecorded messages and auto-dialers; safeguards consumer privacy by restricting unwanted telemarketing communications.
The Joint Commission (TJC)	An independent, not-for-profit organization that evaluates and accredits more than 21,000 healthcare organizations in the United States.
The Patient Protection and	The Affordable Care Act (ACA), or "Obamacare," included reforms to affordability, quality and availability. It aimed to greatly increase the amount of Americans who have access to affordable health insurance; provided assistance for those with pre-existing conditions; extended dependent

Affordable Care Act of 2010 (PPACA)	coverage up to age 26; required coverage of preventative services and immunizations; eliminated lifetime limits on benefits; and expanded Medicaid coverage to more low-income Americans.
The Stark Law	A group of several federal laws that prohibit physician self-referral.
TRICARE	A healthcare program for military active, reservists, and retirees and families.
Unbundling	Fraudulent practice of breaking down services currently bundled together in one CPT code into individual codes for the purpose of higher reimbursement.
Upcoding	Process of assigning an inaccurate billing code for a medical procedure or treatment to increase reimbursement, considered to be a fraudulent billing practice.
Verification of Physician	Be sure to verify that the physician who will be treating the patient is on the panel of providers for the patient's insurance. This is especially important when a patient comes in who is unassigned (does not have a primary care physician) and will be accepted by the physician on call.
Veterans Administration (VA)	Largest integrated healthcare system in America serving veterans who served in the active military for at least 24 continuous months and were discharged or released under any condition other than dishonorable (some exceptions exist).
Veterans Choice Program	Program where the VA enrolled member is authorized to receive care from community-based providers.

APPENDIX: PRACTICE QUESTION ANSWER KEY

Customer Experience Questions:

1. C
2. D
3. C
4. A
5. B
6. B
7. C
8. B
9. C
10. C

Regulatory Compliance Questions

1. B
2. C
3. C
4. B
5. A
6. C
7. A
8. A
9. C
10. B
11. C
12. A
13. A
14. B
15. C
16. A
17. B
18. A
19. B
20. A
21. A
22. B
23. C
24. A
25. B

Revenue Cycle Questions:

1. D
2. B
3. D
4. A
5. D
6. D
7. C
8. True
9. B

Information Systems Questions:

1. B
2. B
3. D
4. B
5. C

Resource Management Questions

1. A
2. D
3. A
4. B
5. A

Scheduling Questions:

1. A
2. A
3. B
4. C
5. A
6. A

Pre-Registration Questions:

1. A
2. B
3. E
4. A
5. A
6. C
7. B
8. B
9. A
10. D

Patient Check-in, Admission, Registration Questions:

1. D
2. D
3. C
4. A
5. D

Patient and Family Experience Questions:

1. C
2. D
3. C
4. D
5. C
6. B

Bed Management Questions:

1. B
2. A
3. D