

# Patient Access ADVISOR

INNOVATIVE SOLUTIONS FOR THE FRONT END



## Four days and off you go Intense registration training puts Boca Raton on the right track

Two years ago, the patient access team at Boca Raton (FL) Community Hospital did not have a formal training program. For a facility whose patient mix is 60% Medicare, that is not a good thing.

"[Managers] just sat with them," says **Michele Vail**, manager of patient access at the 400-bed facility. "There were no documents, no tools. They didn't have a steady manager."

That all changed in 2007 when Boca Raton began a formal training program for new registrars—a four-day crash course of just about everything access staff members need to know. It includes training in HIPAA rules, the federal Emergency Medical Treatment and Active Labor Act (EMTALA), managed care, and basics in personal injury protection (PIP), among other information.

The new program has changed the face of patient access at Boca Raton, making it a respected division of

the revenue cycle and helping it achieve near-100% accuracy levels.

"We really saw an increase in staff knowledge," Vail says.

The four-day training program has helped in many other ways, including:

➤ **Better chemistry among departments.** Boca Raton has decentralized registration, so the program brought staff members together and "humanized a lot of us," Vail says.

➤ **Consistent supervision and monitoring.** Boca Raton gave its quality control representative, Anita Healey, added responsibility for training. "All day long, we had

her looking at charts, charts, charts," Vail says. "We felt she should be talking to staff more and explaining

**"I want them to know that we're approachable. There's a wealth of knowledge they need to know, and we want them to not be afraid to come to us for fear of retribution."**

—Michele Vail

things. So we added that type of training to the job description." (See Boca Raton's quality control representative job description on p. 5.)

➤ **Improved accuracy rate.** Boca Raton's accuracy rates increased from 87% in August 2007 to 97% in May.

➤ **Confident, self-sufficient staff members.** Staff members have greater problem-solving abilities. Most are now confident enough to ask for payment and explain to patients that it is their responsibility to pay the appropriate costs at discharge. Additionally, if staff members do not understand something, they are able to find the answer on their own. They look up the answers to their questions using what management calls a "registration bible." They also ask

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HCP Pro

## Four days

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one another for help instead of having to rely on the manager.

- **More time for management.** “The less they ask, the more we get done,” Vail says. “We’re not always here 13 hours a day.”

## A four-day affair

The patient access department at Boca Raton breaks down the four-day training program into categories and subcategories and sets goals regarding how long each training module should take. It works like this:

- **Day one.** The opening half hour of day one is devoted to a summary of HIPAA. Management teaches staff members the various acronyms and discusses the dos and don'ts that could spell trouble in terms of HIPAA compliance.

An introduction to EMTALA is given in the following 30 minutes. Boca Raton management talks about the delay-of-care issue versus financial obligations that must be met.



After EMTALA comes a two-hour block on Boca Raton's “pyramid of priorities.” Topics include how to determine coordination of benefits and application toward insurance listings. Boca Raton uses the pyramid to help registrars understand how the registration process works as a whole (see “Access pyramid” on p. 4). The pyramid is included in a PowerPoint presentation that managers give to new registrars.

Next on the agenda is a four-hour session on the basics of the McKesson software system used at Boca Raton, which covers topics such as:

- MPI search
- Patient information
- Guarantor information
- Next of kin/emergency contact
- Medical page
- Physician page
- Insurance page
- Insurance verification/approval/authorization page
- Miscellaneous information page (occurrence codes)
- Account number assignment
- Print options

In the final four hours of the day, staff members receive an introduction to managed care insurance. They are trained to determine whether a patient has regular Blue Cross insurance, the difference between a PPO and an HMO, and other topics, including:

- Insurance master basics
- Matching insurance cards to plan codes
- Correct coding of third-party insurance carriers

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► **Day two.** The second day of training begins with a four-hour introduction to Medicare.

Staff members learn what certain cards look like and get a crash course on Medicare Parts A and B, advance beneficiary notices (ABN), and medical necessity, among other areas.

“[Our new hires are] off the streets working at public supermarkets,” Vail says. “If you don’t teach them this, it’s going to make their heads fall off when they have to do it.”

The introduction also includes:

- Rules and regulations
- Medical compliance
- Medicare Secondary Payer
- Retirement dates
- Occurrence codes

After covering Medicare, five hours are taken to introduce staff members to Real-Time Eligibility (RTE) Relay Health, which is Boca Raton’s eligibility software. The introduction includes:

- How to view responses
- Correct identification of Medicare replacers
- Working aged when Medicare is secondary
- How to match plan codes with RTE messages
- Effective troubleshooting when an RTE error message appears
- Correct identification of Medicare replacers and liability insurance coverage
- Applying facility benefits to specific tests

In the last 120 minutes of the day, staff members receive an introduction to liability and workers’ compensation. Topics covered include:

- The required essential data elements
- Basics in PIP insurance
- Understanding liability coverage amount

► **Day three.** At the start of the third day, basic concepts in Pathways Healthcare Scheduling, Boca Raton’s scheduling module, are covered. This software is used by staff members who do preoperative registrations, as well as radiological and diagnostic scheduling. Topics covered include:

- How to search for a patient
- How to view multiple appointments
- How to print a specific location listing

Thirty minutes are then used to cover the basics in scanning the Horizon patient folder, including electronic medical records, scanning insurance cards, where staff members should scan them, and how to find them. It also includes training on how to view documentation via the facility’s intranet.

Next is an introduction to insurance Web sites. This session lasts one hour and covers the following Web sites:

- United Healthcare
- Availity
- Great-West Healthcare
- Med Solutions
- Vista Health Plan
- CIGNA
- Myinsurancemanager.com (an eligibility Web site)

The final 60 minutes of the day covers customer service and effective scripting, including how to deal with troublesome patients who refuse to pay a copay. The session also includes:

- Answering and transferring calls
- When to use the speakerphone option
- Leaving compliant voice mail messages for all patients
- Overcoming objections on point-of-service collections

► **Day four.** The first order of business on the final training day is a 300-minute review. All information and processes are covered, followed by a question-and-answer period.

After the review comes the registration assessment test, which lasts for one hour. The test gauges whether the registrars have learned enough to start working independently. (See this month’s Training Tool for a set of sample questions taken from the assessment test.)

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## Four days

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After the test, Vail takes 30 minutes to go over the results with each registrar. Registrars then sign a document saying they learned the material and are ready to begin running a registration desk on their own.

The final 30 minutes is a review of Boca Raton's employee rules and regulations. The patient access director, who is Vail's boss, attends this session.

After training, managers keep a close eye on the new registrars for 30 days. At the end of this period, registrars

are reassessed to determine whether they require more training. "I want them to know that we're approachable," Vail says. "There's a wealth of knowledge they need to know, and we want them to not be afraid to come to us for fear of retribution." ■

*Editor's note: A-Plus Access articles focus on enhancing the professionalism of your access staff. If you have an idea for this ongoing series, please contact Senior Managing Editor Dom Nicastro at [dnicastro@hcpro.com](mailto:dnicastro@hcpro.com) or 781/639-1872, Ext. 3413.*

### Access pyramid

Below is the pyramid Boca Raton (FL) Community Hospital gives to registrars to explain how insurances work into the registration process.



Source: Boca Raton (FL) Community Hospital.

This Month's

**Form****Quality control/trainer job description**

The following is the job description for the position of quality control/trainer at Boca Raton (FL) Community Hospital.

- Description title: Quality control/trainer
- Supervised by: Manager—patient access
- Supervisor of: N/A
- General summary: This position is responsible for assisting the department manager in the implementation and operation of the patient access department's Quality Assessment (QA) Program, continuous quality improvement (CQI), and regulatory functions. The position also assists with the coordination of safety, risk management, and agency compliance. The quality control/trainer will be integral in all software and new program installations, testing, and training, and will serve as project liaison as directed by his or her manager.
- Principal duties and responsibilities, also known as function/outputs, include the following (other duties may be assigned, and all duties are subject to change):
  - Completes special projects as assigned by the director and submits reports to the director by the established deadlines.
  - Trains end users on all aspects of their job. This includes new staff member training, implementation of new programs, and addressing new compliance and regulatory issues.
  - Develops and maintains training curriculum for all patient access positions.
  - Performs and coordinates audits for patients of all insurance types for appropriateness of patient type assignments.
  - Performs and audits Medicare Secondary Payer questionnaires for completion and accuracy.
  - Coordinates system updates according to CMS guidelines and training for all patient access employees.
  - Develops and maintains competencies and validation tools specific to patient access.
  - Coordinates and performs audits of patient accounts in accordance with hospital, federal, and state guidelines.
  - Follows QA plan and organizes assignments to achieve stated objectives.
  - Works with ancillary departments when problems occur.
  - Monitors federal and state regulations for issues affecting the patient access department and relays information to appropriate staff members.
  - Works closely with patient access leads to implement CQI processes.
  - Assists with compliance, safety, risk management, and regulatory issues and training.
  - Assists with maintaining and updating patient access policies and procedures.
  - Educates and trains patient access representatives on findings and procedural changes.
  - Assists in maintenance of all quality foreign software applications.
- Job specifications (also known as competencies):
  - Knowledge, skills, and abilities: Previous hospital registration experience required.
  - Education and/or experience: Bachelor's degree from four-year college or university, or one to two years related experience and/or training, or an equivalent combination of education and experience.
  - Language skills: Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, and governmental regulations. Ability to write reports, business correspondence, and procedure manuals.

➤ **Download this entire form in the **Patient Access Advisor** section of [www.accessresourcecenter.com](http://www.accessresourcecenter.com).**

Source: Boca Raton (FL) Community Hospital.

# Assess your registration processes

## Use these 10 tips to focus your review

by Steven G. Orvis, MPH

*Editor's note: This is the first article in a two-part series.*

*Coming in next month's issue: Recommendations for resolving your registration processes.*

As registration processes become more complex and registration teams are expected to perform an increasing number of tasks, it might be a good time to take a step back and assess the various aspects of your registration process.

You can't decide where you want to be unless you know where you are. Once you assess your current processes, you can prioritize the problems and identify the steps you will need to take to resolve them.

As a manager, you know that all processes require evaluation. But why has registration become such a hot topic?

For one thing, recent studies have shown that 15%–20% of all registrations have some lack of data integrity. And when demographic information such as incorrect codes is factored in, that number rises to 50%–70%.

### Start assessing with this list

As you begin to assess your processes, there are certain key points you should address. Although all of these points can be broken down into multiple subtopics, start with this list to identify the areas in your registration process that may need particular attention:

**1. Centralization vs. decentralization.** Most facilities have a combination of centralized and decentralized processes. Although changes to this structure are usually not easy fixes, it is still important to understand how your structure is affecting your efficiency and customer service.

Centralization or decentralization is not inherently bad or good. Both systems have advantages and disadvantages,

and which system works best for you depends on factors such as your facility's physical layout. However, even within each type of structure, there are certain questions you should ask:

- Are registration processes consistent among registration sites?
- Is there standardization of specific roles, such as scheduler and registrar, among the sites?
- Is training consistent?
- Do all sites have quality assurance?

**2. Registration as part of the revenue cycle.** Registration staff members do not always view the registration process as part of the revenue cycle. They may view registration as a low priority since it is a non-revenue producing activity.

As a result, they may not understand the effect that front-end mistakes have down the line, especially if those mistakes need to be resolved by patient business services (PBS).

It is valuable for front- and back-end staff members to understand each other's functions, and to know how they affect each other's processes. For example, if PBS has to take extra time to resolve front-end errors, this will increase expenses and delay payment. In addition, it is not appropriate for back-end staff members to resolve registration or coding errors, because these are not their areas of expertise.

**3. Customer service.** Quantify any customer service issues that arise from registration processes. One way to do this is to audit the number of calls received for specific registration mistakes, such as incorrect payer entered, wrong demographic information, and authorizations obtained by the patient but not entered into the system.

Alternatively, you could count the number of mail returns over a certain period. This will give you an idea of the amount of incorrect demographic information entered.

**4. Data integrity.** Do your registrars and schedulers ask the right questions of the patient? For example, do they ask, "Has your address or insurance changed?" Or do they ask the patient to state their address and payer information?

Is there an overall understanding of how to interpret insurance cards? Is it clear which address should be entered for the billing of claims? Does your team understand which payer covers each service?

Are documents such as authorization and insurance cards obtained and scanned appropriately? If not, this will delay billing and require additional work on the back end. Is there an overall understanding of how and when to verify medical necessity and when to obtain an authorization for a particular procedure? Are advance beneficiary notices (ABN) provided consistently, and do staff members understand when ABNs must be obtained?

Review the general understanding of Medicaid documents. Is Medicaid billed for services that are not covered? Are authorizations obtained? These issues, as well as verification of Medicaid eligibility, are particularly important, as Medicaid patients may be able to change enrollment monthly.

**5. Training.** This is one of the most important areas to review, as many issues you identify will be traced back to a training issue. In certain situations, the training quality and frequency itself may be the issue. Is training consistent and standardized? Is it mandatory or voluntary? Once training has ended, is there quality assurance and follow-up?

**6. Policies, procedures, and job descriptions.** You must document policies and procedures to ensure that processes are understood and followed consistently. Likewise, job descriptions should be documented and understood by staff members. This sounds obvious, but it is surprising how often policies and job descriptions are not updated or reviewed with the staff members who are expected to follow them.

Ask yourself whether there are specific procedures for all front-end tasks, not just for insurance verification and

demographic collection, but for other tasks such as cash handling and collection of copayments.

Do job descriptions identify all the duties required, and does your team understand specific expectations, such as productivity standards? Do staff members know all the functions for which they are responsible?

**7. Financial screening.** Although almost all facilities have financial counselors, there is a wide variation as to how integrated they are with the revenue cycle. At many facilities, preregistrars may handle the financial screening process.

In any case, it is important to assess how quickly the financial counselors are brought into the registration process. For example, are they readily available to assist with sponsorship or screening or both? Are they stationed at high-volume registration sites? Do registration staff members understand the circumstances under which they would refer a patient to a financial counselor?

**8. Software tools.** Technology is a main driver of front-end efficiency, but this does not mean you have to spend an inordinate sum of money to upgrade all of your front-end systems. There are bolt-ons and modules that can be added to most eligibility systems, and you may be able to turn on features of your current system that are not being used.

Industry standard software will include appropriate scrubber tools, registration and eligibility software, and, often, medical necessity software. The most efficient software systems automate much of the review process and let users build edits or rules against the registration fields so that potential errors are automatically flagged. This is important because edits will be identified at the time of registration rather than after the claim is produced.

You should also identify the number and types of hard stops (fields that must be populated) that are present. Determine which fields have caused the most registration errors and ensure that those fields have hard stops or the appropriate flags.

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## Registration process

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**9. Communication with contracting.** You must verify that any staff members performing preregistration or registration tasks understand and have access to all applicable contracts and contract terms. This will mean that those who compose the contracts need to distribute contract copies as soon as they are signed (preferably electronically).

Train your staff members so they are aware of the contract terms that affect registration. For example, some contracts explicitly state whether claims are to be sent to the medical group or health plan. Likewise, the contract should state what services are included or excluded, co-pay amounts, etc.

Another reason to have ongoing communication with contracting team members is that those who work with the contracts (e.g., registration personnel, billers, and collectors) know what terms and provisions are difficult to put into practice or are confusing. Listen closely to those staff members; their input is invaluable.

**10. Denial management.** It is important to look at the types and volume of denials you are getting that are related to front-end process, such as:

- Patient not eligible on dates of service
- Other payer should be primary
- Service not authorized
- Service is not a covered benefit

In addition, many of your front-end denials may be hiding in a denial for lack of timely filing. In those cases, the original denial may be a result of the claim being sent to the incorrect payer, but by the time the error is resolved and the correct payer is billed, that payer may reject the claim for untimely filing.

You should be familiar with the volume and costs of denials, and focus on the processes that are causing the greatest number of those denials. In addition, determine whether denials are coming from particular payers or departments (the latter is particularly important if your registration is decentralized).

### Look at the whole picture

Look at the preregistration/registration process as a whole rather than focusing on one or two issues. View the process as a related work flow rather than a compilation of separate processes. You will often find that one or more processes will affect other steps, so it is important to assess the entire work flow to determine where you have roadblocks. ■

*Editor's note: Orvis is a healthcare consultant with more than 25 years of progressive experience in physician and hospital business office and outpatient services management, in addition to performance improvement consulting. He is based in Los Angeles.*

### Question of the month

## HINN 11: When should you use it?

**Q** We have a question regarding Hospital-Issued Notices of Noncoverage (HINN) after reading "Administering the new HINNs" in the June PAA. Can you give examples of items or services for which we should deliver an HINN 11? Recently, a patient at our facility asked for her monthly osteoporosis medication. She was an inpatient at the time, but the medication was not related to her stay. Would an HINN 11 be appropriate in this situation?

**A** HINN 11 is appropriate only to notify a beneficiary of his or her liability for noncovered severable services, or services unrelated to the reason for that particular inpatient stay, when all of the following criteria are met:

- The item or service is excluded from coverage as medically unnecessary under a written Medicare policy
- The beneficiary requires a continued inpatient stay
- The inpatient stay is covered under Medicare Part A

- The item or service is not bundled or integral to payment or treatment for the diagnoses or reasons justifying that inpatient stay

HINN 11 would be appropriate in the following scenario: A patient admitted as an inpatient is being treated for pneumococcal pneumonia (481) with pneumonitis due to toxoplasmosis (130.4). During the otherwise Part A-covered stay, the physician orders a PET scan for breast cancer, which does not meet Medicare's medical necessity guidelines.

The PET scan is not bundled into or integral to payment or treatment for the diagnoses or reasons justifying the covered inpatient stay. In this case, the hospital may notify the patient and the attending physician, using HINN 11, referencing NCD PET (FDG) for Breast Cancer, 220.6.10.

If you have a question as to whether to use HINN 11 for particular services ordered in the inpatient setting, check with your FI or MAC. In particular, the hospital

must reference a written Medicare policy to support the hospital's position that the particular item or service is excluded from coverage as medically unnecessary. ■

*Editor's note: Judith L. Kares, JD, CPC, answered this month's question. Kares is an instructor for HCPro's Medicare Boot Camp®—Hospital Version. She is a lawyer/consultant who provides legal services and related healthcare compliance services to a wide variety of clients, including hospitals, health systems, HMOs, third party payers, physician practices, and other healthcare entities. Visit [www.hcprobootcamps.com](http://www.hcprobootcamps.com) for more information.*

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### Case study

## Show, don't tell

### A manual approach to quality could lead to an automated system for your facility

The best way to get approval to install or implement an automated quality assurance (QA) system for your facility may be to first create a manual one.

Manually attaching real numbers to existing labor costs and errors could show the need for an automated system better than simply stating that one is necessary.

That philosophy worked for **Amanda Watson**, QA specialist in admitting at Community Regional Medical Center in Fresno, CA. Instead of simply telling management she needed an automated system, she showed them why.

Watson and her team created an Excel spreadsheet in which they manually tracked errors, how much time and money those errors cost the facility, and the total cost of rework necessary to right the wrongs. After showing

the spreadsheet to management, Watson got the okay to invest in an automated QA system. This system has brought about:

- Improved accuracy rates
- Motivated staff members with improved job satisfaction
- Decreased A/R days
- More time for managers to do other tasks

The biggest problem before the implementation of Community Regional's automated QA system was the limited amount of work managers and assurance specialists could view, Watson says.

Watson works in a system that has two facilities, multiple clinics, and about 700 licensed beds. The manual

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## Case study

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Excel spreadsheet helped shed light on the work being done across the facilities. For example, it showed that the QA staff was able to check 1,500 addresses per month, taking 2.5 minutes per address and costing Community Regional \$13,425 per year.

Now, with an automated QA system that shows the errors in real time, the facilities check 50,000 accounts monthly before they go out the door. This has led to a more than 33% decrease in wrong address mail returns.

“With a manual [QA] system, there’s always a chance for errors,” says **Steven G. Orvis, MPH**, manager at a consulting firm in Los Angeles. “The problem when you do the auditing is that it’s very labor intensive for the auditor, and you can’t get enough of a sample.” (See “Cost of quality” on p. 11 for information on how much errors can cost a facility.)

Problems under the manual system included:

- **Inconsistent monitoring of staff members’ work.** The facilities had two QA specialists working on thousands of accounts assigned to 120 registrars. The registration process is decentralized, with an additional 100 registrars that do not work for admitting, and quality monitoring was not performed. It was impossible to consistently view one registrar’s work for a long period of time.
- **Unverified addresses and incorrect insurance policy formats.** The facility learned about these errors the hard way—through returned mail receipts and denials.
- **Poor customer satisfaction.** Patients complained when they received bills months after their visit because of initial mailing address errors.
- **Uncertainty with costs.** “We weren’t really aware of how much this stuff costs us,” Watson says of tracking errors manually. “Is it really that big of a deal? When you start looking individually at costs, it adds up.”

Since management approved the purchase of an automated QA system, those problems have gone away. And

the cost of the new system (AHIQA) is far less than the labor and financial hits taken by tracking errors manually, Watson says. In addition, Community Regional’s revenue cycle has benefited from:

- **More accounts reviewed.** Rather than perform the QA tasks manually with two specialists, the system monitors the errors in real time. The new system can verify 50,000 addresses per month compared to 1,500 prior to implementation.
- **Improved return on investment (ROI).** Although Watson says she can’t measure this to an exact dollar amount, she knows the facilities met their ROI within five months of purchasing the automated system.
- **Cleaner claims.** Incorrect street names, ZIP codes, and other address details are caught ahead of time. The facilities have had a more than 33% decrease in return-to-sender errors.
- **A lighter workload for managers.** Checking to see whether consents are signed and verifying addresses was a constant battle in the manual process. But these headaches are now gone. The automated system frees up time for education as well. Previously, there was no good way to monitor new employees.
- **Better accuracy rates.** By measuring accuracy for things such as demographics, insurance plans, and addresses, the facilities have seen their accuracy rate increase from 84% in November 2007 to 97% in June of this year.
- **More-competent staff members.** Registrars have better self-esteem, Watson says. “We did a little bit of team building. We’re transparent about our scores, and there’s a little bit of competition there,” she says.

Regardless of how you convince your senior management team of the need for an automated system, you must involve your staff in the process from the outset. “Maybe you could let them help pick the product,” says Watson. “If you have the buy-in from them, they are going to accept the product and work with it better.” ■

## Six tips for quality control auditing

The quality assurance (QA) team at Community Regional Medical Center in Fresno, CA, used hard numbers to show the need for automated QA software at its facility (see the related story on p. 9).

Regardless of whether you use a similar approach, consider the following helpful tips and reminders from healthcare consultant **Steven G. Orvis, MPH**, for use in auditing your QA program:

- **Eliminate subjectivity on the front end.** Software providers can create lists of customized services that physicians regularly provide. When a service is ordered, staff members enter a diagnosis code, and the software determines whether it meets medical necessity. It can also generate an advance beneficiary notice as necessary. The advantage of having this as part of the front-end tools is that it is difficult to train staff members to make medical necessity determinations, and this eliminates subjectivity.
- **Get it right before the visit.** Software is available that will match members to their health plans and

benefits prior to their visit, thus reducing or eliminating the chance of insurance verification errors.

- **Customize your own rules.** Registration scrubber software automates much of the review process and lets users build edits and rules. The rules allow users to automatically check for required fields. The system can also take this information and build worklists for auditors.
- **Comply with HIPAA early.** HIPAA provides an electronic standard for eligibility verification. Verifying eligibility during the scheduling process or preregistration is a best practice.
- **Beat the billing scrubber.** Failure to review the accuracy of registration data before the billing scrubber review will delay the billing of the claim.
- **Don't disregard training.** The best software system in the world cannot replace face-to-face training. You must have an adequately trained team, including tools and processes for formal and consistent QA and training. ■

### Cost of quality

The following is a spreadsheet used by the quality assurance (QA) team at Community Regional Medical Center in Fresno, CA, to monitor errors, labor, and time costs. The spreadsheet convinced management of the need for an automated QA system.

Admitting cost-of-quality analysis									
Problem description (e.g., phone repair):						Type:			
Tasks	Task time in minutes	Average hours/task	Average hourly rate	Cost of task	Cost of materials	Other failure costs	Total cost of nonconformance	Incidents per month	Annual costs
Run POS—not ran initially or incorrectly	4.5	0.08	\$15.50	\$1.16	\$0.10		\$1.26	60	\$909
Reprint COA, mcr msg, HIPAA, stamp, sign	5	0.08	\$15.50	\$1.29	\$0.10		\$1.39	60	\$1,002
Run insurance benefits	5	0.08	\$15.50	\$1.29	\$0.50		\$1.79	12	\$258
Rescan upside-down COA	10	0.17	\$15.50	\$2.58	\$0.50		\$3.08	25	\$925
Move missed scanned docs	6	0.10	\$15.50	\$1.55	\$0		\$1.55	10	\$186
USPS: Address not validated	2.5	0.04	\$15.50	\$0.65	\$0.10		\$0.75	1,500	\$13,425
Update accounts due to missed info	5	0.08	\$15.50	\$1.29	\$0.10		\$1.39	200	\$3,340
Defer & delay due to no benefit notification	2	0.03	\$15.50	\$0.52		\$35	\$35.52	10	\$4,262
			\$15.50	\$0			\$0		\$0
Total cost of rework									\$24,307
1. Lost opportunity costs						\$0			\$0
2. Lost assets costs						\$0			\$0
3. Lost business costs						\$0			\$0
Additional failure costs									\$0
Annual failure cost									\$24,307
Basic tasks to fix the problem	Time in minutes	Average min/60	Loaded rate	Calculated cost	Expenses				Total

Source: Community Regional Medical Center, Fresno, CA.

## PAA names Albany access manager to advisory board



**PAA** named **Catherine M. Pallozzi, CHAM, CCS**, to its advisory board in June. Pallozzi, patient access director at Albany (NY) Medical Center, has worked in healthcare for more than

25 years managing the revenue cycle. She has been with Albany Medical Center for 20 years. Albany is a 631-bed Level I tertiary care teaching facility with a 250-hospital-based physician practice. It provides care to 25 counties in Eastern New York and Western New England.

As a member of the National Association of Healthcare Access Management (NAHAM) since 2002, Pallozzi received her CHAM in 2004, and has been certified as a coding specialist through the American Health Information Management Association since 1993.

Pallozzi says her proudest accomplishment is creating policy and procedure manuals for most of the departments for which she's worked. "Not one was a massive labor of love, but it's just an absolute necessity," she says.

No stranger to the importance of access in the revenue cycle, Pallozzi says the health of a facility's bottom line depends heavily on the work of its patient access team.

"It's been really wonderful to see this evolution of people who collect data into a more respected role in the facility," Pallozzi says. "Facilities are recognizing that access is a critical portal of information, and it's a critical aspect of

customer service in the institution. There's a respect this field has gained due to the hard work of NAHAM. We're seen as experts, as opposed to people who collect names."

### Front end needs support

The challenge for access now, Pallozzi says, is adapting to a new type of patient who shops for healthcare and wants transparency with regard to prices. To support that, facilities must recognize the need for technology so access team members can keep up with demands from patients and the government.

"We're going to need to compete and seek answers

**"Managers really need to ensure that staff members are educated in the revenue cycle ... to be able to assist our patients in making informed decisions about their healthcare needs."**

—Catherine M. Pallozzi, CHAM, CCS

to the questions of our patients who are really seeking out healthcare," Pallozzi says. "Patients are not just listening to what doctors say; they are taking an active part in their care. Managers really need to ensure that staff members are educated in the revenue cycle to equip our staff to be able to assist our patients in making informed decisions about their healthcare needs." ■

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