An MSP checklist

Follow these tips to stay compliant and avoid RAC recoupments

Editor’s note: This is the first in a series of articles on the Medicare Secondary Payer (MSP) Questionnaire.

Coming next month, we talk to a patient access manager at a facility that scored 100% compliance after a CMS MSP audit.

You have enough to worry about as a patient access manager without the Medicare Recovery Audit Contractor (RAC) nationwide hospital auditing program. But you should be focused on it, especially in light of the fact that government auditors collected $12.7 million in its MSP RAC three-year demonstration project.

The following is a checklist of things to understand about the MSP form in preparation for the arrival of RACs (see p. 3 for a related MSP form):

1. Use the form optionally. This is a common misunderstanding in patient access. Although CMS has a requirement to collect and report MSP information, the questionnaire itself is optional.

   In response to a question from HCPro, Inc., after its July 16 Hospital Open Door Forum, CMS said the questionnaire is permissive in nature, but the same type of questions must be asked.

   “Providers may use this as a guide to help identify other payers that may be primary to Medicare,” CMS states in its laws. “This questionnaire is a model of the type of questions that may be asked to help identify MSP situations.”

2. Watch for errors in retirement dates and assumed insurance. CMS reports that most of the recoupments made by the MSP RACs are a result of claims in which Medicare paid a provider when a different health insurance company should have. CMS states that when a Medicare beneficiary gets health benefits through his or her job, the employer’s health insurance company is generally the primary payer. The government also revealed that facilities had entered the following incorrectly:

   – Retirement dates
   – Information on professors in California who teach past their Medicare eligibility age

3. Monitor registrars on current employee information for the working-aged. The worst thing a representative can do is assume Medicare is the primary payer and not ask the necessary questions to determine whether another payer might exist, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and...
MSP checklist < continued from p. 1

compliance at HCPro. More and more patients are working past their retirement age, Hoy says. For example, college professors past retirement age are a known problem for CMS related to MSP and employer insurance.

4. Be creative with your training program. At Community Regional Medical Center & Cedar Campus in Fresno, CA, Amanda N. Watson, CHAA, quality assurance specialist in admitting, knows all about the MSP RACs. They came to her facility and found a 13% error rate in the MSP Questionnaire.

The patient access management team at Community Regional plans to roll out a game show–style Medicare activity with staff members. Their plans are to begin initial training with competency testing, then, after a few weeks, go around and quiz staff members in small groups.

If staff members get the answer right, they get a reward. Planned rewards include a $5 Starbucks gift card, a cafeteria meal ticket, a hospital gift shop certificate, or movie tickets.

“I think that the MSP [Questionnaire] is such a vital part of Medicare compliance, and there should be comprehensive training upon hire and a mandatory refresher annually,” Watson says. “Also, it is a good idea to make sure that staff [members] are always up to date on any changes. The other important piece is to audit the accounts randomly. Not only is it done … but it is done correctly.”

5. Become a member of your facility’s RAC team. Some facilities do not include their patient access managers in a RAC audit preparedness team. However, patient access representatives should be included, says William L. Malm, ND, RN, president of Health Revenue Integrity Services, Inc., in Westlake, OH.

“Team members should represent all facets of the revenue cycle,” Malm states in the HCPro, Inc., white paper Recovery Audit Contractors: Strategic Planning to Combat the Effects of the RAC Program. “Because a form of the RAC focuses on MSP, it is imperative that patient access staff members review this process. Clear policies and procedures based on regulatory guidance need to be reviewed and/or established to ensure compliance. Facilities should train patient access staff members on the MSP and perform competency testing.”

6. Ask the patient accounts department to provide copies of all claims rejected by the Medicare payment system due to MSP issues. Use these claims as individual performance counseling material and as case studies for MSP training at your monthly staff meetings. Staff members can relate best to real examples of MSP opportunities that occur at your facility.
7. **Observe each registrar as a Medicare patient is registered.** Carefully listen to how the registrar asks the MSP questions. Does the registrar recognize when the Medicare patient is confused or does not understand the question? Are the questions asked during registration, or does the registrar complete the form after the patient leaves the office? If the patient gives an incomplete answer, does the registrar pursue the required information, or just assume an answer and move on to the next question? If the patient was seen last month, does the registrar complete the MSP screening, or copy the answers from the previous registration? The answers to these questions will quickly demonstrate the accuracy of your MSP screening process.

8. **Track results by registrar and post the department’s success rate.** Employees pay attention to details that are monitored and tracked. Make 100% MSP accuracy one of your registration department’s annual goals and report progress each month.

9. **Obtain billing information prior to providing hospital services.** “It is recommended that you use [CMS’] questionnaire or a questionnaire that asks similar types of questions,” CMS writes on its Web site at www.cms.hhs.gov/medicaresecondpayerandyou.

10. **Process the MSP with correct codes.** “Submit any MSP information to the intermediary using condition and occurrence codes on the claim,” CMS states.

   **Editor’s note:** Tips 6–8 were taken from The Patient Access Director’s Handbook, a Patient Access Resource Center book by Sandra J. Wolfskill, FHFMA, and Marilyn H. Lipka, MBA, published by HCPro, Inc.

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**Form**

**Medicare accident detail form**

Accidents can introduce a payer or payers primary to Medicare. The accident portion of any Medicare Secondary Payer Questionnaire has proven difficult for all entities required to register Medicare patients. The Medicare accident detail form is not required by CMS, nor does CMS have a current version of a form with this intent. This is a form designed to capture information beyond a compliant questionnaire that has proven helpful in securing accident-related payer information for Medicare patients.

Dear Medicare patient:

Hospital records indicate that you received medical care for a condition that is typically the result of an accident. Federal law requires all Medicare patients to answer the following questions as they relate to the dates of treatment. Medicare uses this information to determine the proper payer order for patients. Thank you.

**Medicare patient information**

Patient name: _____________________________ Hospital name: _____________________________

Date: _____________________________ Hospital account #: _____________________________

Date of service – From: _______________ To: _____________________________

Person who supplied information: ________________________________________________

Relationship to patient: _____________________________ Hospital representative: _____________________________

1. **Workers’ compensation (WC)**

   Should the illness/injury be covered by a WC claim? _____ Yes _____ No (If “No,” go to question 2)

   If “Yes,” what happened? _____________________________________________________________

   Original date of illness/injury: _______________ Claim number: _____________________________

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This Month's Form

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Name of WC plan: _______________________________________________________________

Mailing address: _________________________________________________________________

City: ______________________________ State: _______________ ZIP: _________________

Name of employer: ______________________________________________________________

Mailing address: _________________________________________________________________

City: ______________________________ State: _______________ ZIP: _________________

2. Non-work-related accident

Are these services the result of a non-work-related accident? _______ Yes _______ No

If “No,” please explain why treatment was necessary for the services in question: __________

_______________________________________________________ (If “No,” stop at this point)

If “Yes,” what happened? (e.g., slip, fall, auto accident, etc.) __________________________

Date of accident: ____________ Where did the incident occur? _________________________

If applicable, address where the incident occurred: ___________________________________

A. Nonliability/no-fault insurance

Is nonliability insurance available (e.g., auto medical coverage, no-fault, homeowner’s premises)? _____ Yes _____ No

If “No,” who verified this data? ____________________________________________________

If “Yes,” name of the insurance company: _____________________________________________

Mailing address: ___________________________________________________________________

City: _________________________________ State: _______________ ZIP: ___________________

Who is listed as the insured? _______________________ Claim number: ___________________

If no claim number filed, describe why: _______________________________________________

B. Liability insurance

Do you think someone else is responsible for the accident/injury? _____ Yes _____ No

Note: The act of holding an entity responsible entails pursuing and/or receiving financial reimbursement as a result of the accident.

If “Yes,” name of responsible party: ________________________________________________

Responsible party’s insurance company: _____________________________________________

Mailing address: ___________________________________________________________________

City: _____________________________ State: ________________ ZIP: _____________________

Claim number: ___________________________________________________________________

3. Attorney information

Does an attorney represent you concerning the above-described incident? _____ Yes _____ No

If “Yes,” please provide the below information about your attorney:

Name: __________________________________________________________________________

Address: ________________________________________________________________________

Telephone #: _________________

Source: Kevin Willis, Claim Services, Inc., Naperville, IL. Used with permission.

Front end meets back end
For three facilities, bringing financial services together with access is a plus

Some patient access teams simply do not associate with patient financial services if they do not have to.

If this is the situation at your facility, you might want to reconsider, because some patient access managers say they have reaped the benefits of becoming more united with the facility’s financial services team.

Many hospital revenue cycle departments are facilitating regular meetings between the back- and front-end departments. More pressure is on facilities to bill accurately, increase up-front collections, and have a transparent pricing policy. With Medicare’s Recovery Audit Contractor (RAC) program coming to hospitals nationwide in 2010, it is more critical than ever to have communication between the billing department and patient access.

Sandra J. Wolfskill, FHFMA, president of Wolfskill & Associates, Inc., in Chardon, OH, says it is extremely important for both departments to work together.

“It is very easy to sit back and point fingers when information is missing or incorrect,” Wolfskill says.

So what’s a better solution? She says both sides simply need a better understanding of how things work on the other end. She says departments need to:

➤ Understand why all the information on both ends is needed
➤ Understand why it is not always possible to get the information
➤ Work together to implement solutions so that by the time a claim reaches patient financial services, it is ready to bill
➤ Understand what each denial is, why it is happening, and have a stake in cleaning up processes so that denials are reduced or eliminated

“And then develop a strategy to eliminate that cause, thereby eliminating that type of denial.”

Palmetto: Weekly meetings can help improve communication for patient access

At Palmetto Health Richland Hospital in Columbia, SC, perhaps the most common misconception the billing department has about its patient access colleagues is volume of errors, says Charlene B. Cathcart, CHAM, director of admissions and registration at the hospital.

If two errors filter out on the back end, there may be the belief that this sort of thing happens all the time.

Additionally, billing staff members sometimes have trouble realizing how important some front-end tasks are, Cathcart says.

“The sense of urgency and priority is not always a shared thing,” she says. That can lead to delays in changing processes. Something patient access sees as urgent might not be marked as such on the back end.

“There are some things that can’t wait,” Cathcart says.

Palmetto bridges the gap as best it can through weekly meetings for the patient financial services and patient access departments. There are meetings at the director/C-suite level and for managers and supervisors.

The teams go through “all the components of the revenue cycle,” Cathcart says. They also highlight accomplishments and opportunities and how each team can help the other.

From those larger meetings came subgroups dedicated to hot-button issues.

As of July, there were six teams:

➤ Bad debt/self-pay
➤ Denials
➤ Unbilled accounts
➤ Banking
➤ Point-of-service collections
➤ Accounts/receivable billing

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Financial services  < continued from p. 5

“Those work groups look at everything,” Cathcart says. As a result of the meetings between different departments within the revenue cycle at Palmetto, Cathcart says the benefits have been:

➤ The reduction of discharge-not-final bills
➤ Better recognition of others’ duties and processes
➤ Increased point-of-service collections

CoxHealth: Root of data entry errors found

With 300 registrars at three acute care hospitals in the CoxHealth system, it is not easy to point the blame at any one of them for a data entry error.

So when the Springfield, MO–based health system began to see errors such as incorrect addresses and insurance plan codes pop up with more frequency, their revenue cycle team began to look at the entire process rather than singling out individuals.

A major part of that process began with facilitating monthly meetings for the patient financial services and patient access departments.

This approach revealed the first problem: the back end was simply correcting the errors of the front without telling them. “We were making data entry errors that the front end didn’t know about because the back end was sitting there correcting them day after day,” says Brandon C. Horine, business analyst in admission services at CoxHealth. “We’ve now opened communication from the back end to the front end so that it’s done right the first time. It prevents any headaches patients might experience with their bill.”

CoxHealth began the monthly meetings in May. They include directors, managers, supervisors, education services, information technology, registrars, and billers.

“It’s to [help] understand being in someone else’s shoes,” Horine says. “It’s understanding what others go through on a day-to-day basis.”

CoxHealth’s patient financial department is composed of 84 staff members, including billers and other roles, and 10 managers.

Meeting with the large patient access team has helped the health system do the following:

➤ Improve quality for registration/billing purposes
➤ Identify resolutions through continuing education and/or technology that it presently uses
➤ Establish a follow-up process to avoid a breakdown in precertification data entry into its billing system for its point-of-service areas
➤ Remove a data entry field in its software system that created billing issues
➤ Craft an educational newsletter that will be sent to all members of the centralized and decentralized registration areas and posted on CoxHealth’s Web site

“Our first meeting went really well,” Horine says. “Everybody was really excited to meet each other. We always send e-mails back and forth, but now you can start relating with each other and become a big team. But you have to have structure. You don’t want to have an open forum. And it’s good to have an action-item tracker.”

Vail Valley: You do my job; I’ll do yours

Many departments sometimes think other departments should experience what it’s like to be in their shoes. This is exactly what’s done at Vail (CO) Valley Medical Center.

Billers sit at the desks of registrars and vice versa. It helps them focus on the process instead of the people when mistakes are made, says Tracy Walsh, LCSW, director of patient access and case management at Vail Valley.

“When they swap, they really learn ‘what I do that affects others,’ ” Walsh says. “Billers can see why there would be a delay of payment when someone does not read an insurance card correctly.”

The end results have been terrific, Walsh says. Because of the front- and back-end teams working together, Vail, a 58-bed facility, has:
Decreased its returned mailings by 30% by correcting address and insurance information

Increased its point-of-service collections by 50%

Realized an increase in satisfaction among staff members through its public rewards, such as giving a mention to the registrar who has collected the most money

“It’s helped in the relationship in both areas,” Walsh says. “I think we’re finally getting away from that assumption that someone did something wrong. And it is hard to point fingers at someone you know. We now say, ‘Let’s look at this and what you can do to fix it.’ They get that big-picture understanding that ‘This is my job and this is what I do.’ Everyone is a piece of the puzzle.”

Case study

Build a patient-first access team

Washington facility revamps its customer service approach

Perhaps one word best described Skagit Valley Hospital’s customer service in its patient access department a few years ago: poor.

That was not the only problem for the Mount Vernon, WA, facility, says Michele Hill, CHAM, its patient access manager who joined the team in June 2006.

“One of the first things I did was an initial assessment to see where things stood,” Hill says. “It was obvious from the very beginning this department was in crisis.”

Hill says the problems included:

- Staff members’ lack of knowledge of the registration process
- Poor customer service
- An error rate greater than 50% in registration
- Consent forms not obtained
- Lack of basic registration requirements, such as verification of insurance eligibility

“It was a sad state,” Hill says. However, thanks to the leadership of Hill and the dedication of her team, the patient access department at Skagit Valley has improved to a 92%–94% accuracy rate and, following the hospital’s new service standards program, revamped its entire customer service initiative. Patient satisfaction skyrocketed, she says.

Customer service improved so much that Hill and her director were invited to speak about it at the August conference Proven Strategies to Streamline Upfront & Back-End Revenue Cycle Processes in Washington, DC.

“One of our first goals was to create a compassionate experience for the patient,” Hill says. “Everyone walking through that door is having some type of event in their lives. Each person must be welcomed and treated with respect, compassion, and courtesy.”

The following tips are taken from the components that made Skagit Valley’s effort a success:

- Help staff members understand the revenue cycle and recognize the importance of their role.

Hill scheduled staff meetings during which representatives from different departments of the revenue cycle explained to the team how important registration was in the revenue cycle continuum.

“It was incredible to see my staff members’ faces as they became truly aware of the importance of their role,” Hill says. “You have a finance manager telling them that they also worked in registration while attending college and have walked in their shoes. Of everything I did, bringing these people in to help my team understand the revenue cycle elevated their own feelings of self-worth and broadened their understanding of the process. We constantly emphasized that patient access staff members are healthcare professionals too.”

- Do it like Disney.

Fred Lee, author of the book If Disney Ran Your Hospital: 9 ½ Things You Would Do Differently,
Case study  < continued from p. 7

spoke to the entire team at Skagit Valley Hospital. Lee reminded managers how service standards should be a part of every staff meeting. He also stressed a balance of critiques and pats on the back.

Through the efforts of the service standards team and assistance from Lee, the facility has adopted service standards of safety first, then courtesy and compassion, presentation, and efficiency.

“Our service standards have helped us define a new way of being as an organization,” Hill says.

➤ Make a list of acceptable and unacceptable behaviors. Brian Wong, of the Bedside Project in Seattle, has worked with Skagit Valley Hospital leadership and midlevel management to determine acceptable and unacceptable behaviors, moving to a culture of compassion and implementing service standards. Hill’s patient access team adopted a set of universal attributes to help the team become the best it could be.

“One quote that we have referred to often,” Hill says, “is [self-help author Stephen R. Covey’s] ‘Between stimulus and response, there is a space. In that space, I have the power to choose ... safety, compassion, presentation, and efficiency.’ ”

Some of the universal attributes that were adopted include being responsive and respectful, having a positive attitude, being team- and patient-focused, teaching and learning, and bringing out the best in each staff member.

➤ Encourage staff members to help other departments. Hill says one of the first things on the list of unacceptable behaviors is for a staff member to say, “It’s not my job.” “That has made a big difference here,” Hill says. “We’re all here to support each other.”

This has led staff members to realize the importance of helping patients at any time, regardless of whether they need the services of patient access. Employees and volunteers at Skagit Valley Hospital are all charged with the responsibility to greet each person they come in contact with and escort all patients and visitors to their desired location.

➤ Create a more personable environment. Another service standard focus has been for staff members to introduce themselves to the patients and clearly explain what they are there to help with.

For example, the following is a script used for bedside registration in the ED: “Hi, my name is ________, I’m a member of the care team, and I am here to register you for your visit today.” Staff members end the encounter by asking the patient whether there is anything else they need before they leave the room.

➤ Have a dress code. Whether you go with a formal or casual look, establishing a dress code can have positive effects on your team and the patients.

One problem Hill notices with wearing scrubs in patient access is that patients sometimes confuse patient access staff members with clinical staff members. Skagit Valley Hospital patient access staff members wear a knit vest with the facility’s logo embroidered on it. “The vests have made a real difference.” Hill says. “Patients and visitors comment on how nice we look, and we’re recognized throughout the facility as members of the patient access team.”

➤ Train, train, train. Hill’s department runs ongoing workshops that include role-playing, scripting, customer service exercises, and team-building. “These efforts help create a positive attitude and a compassionate way of interacting with others,” she says.

➤ Hire for attitude. The most advanced computer skills will only get you so far in the patient access world, Hill says. Screen prospective employees for the way they interact with you, how they speak, and their approach to others in the facility.

“I hire for attitude,” she says. “I am really looking for strong customer service and the ability to interact with others from a compassionate place. We can teach registration skills.”

➤ Build team bonds. “We have a great relationship with the other departments in the revenue cycle,” Hill says. “They’re very gracious about sending me back errors
that may delay the billing process. I believe that due to the reconvening of the revenue cycle team, we have developed a wonderful relationship between departments. They have assisted me from day one to know what they need from my department. Due to their time investment, I have had the knowledge I need to help me develop the necessary training tools to improve service to our internal as well as external customers.”

➤ Consider bedside registration in the ED. A new position was implemented to staff the ED check-in desk 24/7, which provides a positive first impression and assists with patient and visitor flow.

Skagit Valley created the position in patient access not to perform registrations, but simply to obtain the patient’s name, date of birth, and his or her reason for visiting; then, staff members contact triage for the patient. Staff members in this position are patients’ first point of contact, and their primary function is to be the start of a great patient experience. This group also assists with clerical chores, freeing time for the registrars to focus more on their primary responsibility of clean, accurate registrations.

➤ Have information easily available. Skagit Valley now provides a patient information folder at the time of admission with important information the patient needs to have readily available.

All paperwork created during the course of a patient’s stay, including discharge instructions and prescriptions, is placed in this folder.

➤ Get out there with your staff members. Hill says it is important for patient access managers to work the front line with their staff members.

“I’m up there as needed, taking calls, greeting people, and registering our patients,” she says. “I believe it reinforces to my staff that we are a team and we’re all in this together.”

Develop a customer service script

Know the right questions to ask

Editor’s note: The following is an excerpt from The Patient Access Director’s Handbook, by Sandra J. Wolfskill, FHFMA, and Marilyn H. Lipka, MBA, published by HCPro, Inc. To see an example customer service script, check out the Training Tool included with this issue.

Scripting involves identifying common situations, activities, and questions posed to patient access and teaching staff members as well as understanding how to answer appropriately to project the caring, professional image of a staff member working hard to exceed the customer’s expectations.

The most difficult part of implementing scripted responses is to develop the appropriate responses and train the staff. To ensure success, all managers and supervisors must be held responsible for monitoring staff members’ compliance with expected responses and statements. If management fails to hold staff members accountable for following the scripts, the entire scripting exercise is a waste of time and money. Hold your staff members accountable for following the scripts so the exercise proves to be time and money well spent.

Getting started

To start a scripting project, first assemble a team of frontline staff members and supervisors. Explain the purpose of the scripting project and get their buy-in on the importance and value to the organization of having a consistent voice when dealing with customers. Establish the project timeline, set standing meeting dates, and review how the scripts will be developed.

Developing the scripts begins with creating a master list of situations and questions from which script ideas will originate.

Examples of situations include:

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Develop a script  
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- Answering an incoming call to the scheduling area from a physician’s office or a patient
- Responding to a physician’s office or patients when the requested time slot is not available
- Starting the preregistration conversation or registration contact with a patient

Examples of questions include:
- “Why do you want money from me now when you have always billed me later?”
- “I’ve been on hold forever. What is going on? Why can’t you people answer the telephone promptly?”
- “I was just at your facility last week. Why do I have to go through all these questions again?”

Brainstorm situations and questions. Take the lists developed at the first meeting and assign team members to review the information and add to the lists. Prior to the next meeting, have one person compile the reviewed materials into a master list for discussion.

Writing the scripts

At the following team meeting, the team should finalize the list of situations and questions. At this time, as the director, you must set the tone for all responses. Take one situation or question and work through a response with the team. Solicit team input, but do not hesitate to add your suggestions in order to craft the type of statement and tone that supports excellence in customer service.

Once you are sure that team members understand how situations and questions are to be scripted, divide the work among team members, capitalizing on the expertise that each member brings to the table.

Assign several team members to work together on their assignments and set a due date for completion of at least one set of scripts by the next team meeting. At the next meeting, have each subteam present its work for review by the entire team. It is helpful to distribute the draft scripts in advance. Finalize the first set from each subteam and set a due date for completion of the balance of the assigned scripts. Distribute the final sets of draft scripts in advance of the review meeting.

Teaching the scripts

After the full team has reviewed and finalized the complete set of scripts, develop the training strategy. How these scripts are presented and explained to staff members is just as important as the work that goes into developing them. The project will fail if you simply print copies, hand them out, and expect staff members to use the materials given to them.

Staff members need to understand why scripts are an important component of your customer service strategy. They need time to understand each script and to paraphrase in their own words. Practice makes perfect, so use a major portion of the training session to conduct role-playing.

Ensure that staff members understand that performance will be tracked and documented based on the use of these scripts and that failure to use these scripts will result in an unacceptable performance rating.

Once all staff members have been trained and the scripts are implemented, managers, supervisors, and the director will need to manage by walking around and listening to staff member conversations on a regular basis. Use a master list of employees and check off each name as you observe their conversations. Make note of anyone who needs additional training and provide it as quickly as possible.

Review scripts, situations, and questions every six months. Check for new problems and questions, and update the scripts accordingly.

The scripting project is never completed; things change constantly in the healthcare revenue cycle. Make sure all new employees receive the updated set of scripts and training materials before they start to work independently.
Advisor's tip

Last quarter is a good time for a review

Editor's note: Catherine M. Pallozzi, CHAM, CCS, director of patient access at Albany (NY) Medical Center and an advisory board member of Patient Access Advisor, provided this tip.

The revenue cycle is interesting. Just when you have the team geared up and on its way, the fourth quarter of the year is upon you.

I find that taking inventory of goals and objectives and ensuring a careful review of all key performance indicators helps in the close of the year-end book. Your team works hard all year long only to lose steam in the closing months. Here's what you can do to help:

➤ **Be sure to review your overall quality as well as individual quality indicators.** Review specifically for trends and ensure that any necessary remediation is completed.

➤ **Review all your opportunities for collections.** Review your trending. With a new strategy, are there areas in which collection can be improved?

➤ **Ensure that all your staff members are made aware of keeping their key performance indicators at the department target.** If you complete a dashboard of indicators for staff members, September is a perfect month to review with them. They will have ample time to make a correction that can affect the bottom line by December 31.

➤ **Rally the troops.** The fourth quarter ramp-up for a strong close is an important aspect of the revenue cycle.

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**Sample ED registration error log**

Editor's note: Pallozzi uses this form to monitor registrars' work. It is one way to review your processes this fourth quarter.

<table>
<thead>
<tr>
<th>User</th>
<th>Medical record #</th>
<th>Serial #</th>
<th>Status codes</th>
<th>Plan code</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>knm</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>4e</td>
<td></td>
<td>Wrong plan code</td>
</tr>
<tr>
<td>mab4</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>1a</td>
<td></td>
<td>Wrong punctuation in address</td>
</tr>
<tr>
<td>mab4</td>
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<td>xxxxxxx</td>
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<td>xxxxxxx</td>
<td>1a</td>
<td></td>
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</tr>
<tr>
<td>exp</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>1b</td>
<td></td>
<td>Wrong telephone number and name of next of kin</td>
</tr>
<tr>
<td>cel</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>1b</td>
<td></td>
<td>Wrong telephone number</td>
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<td>No Omnipro or Blue Cross sign-on</td>
</tr>
<tr>
<td>cjo</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>1b</td>
<td></td>
<td>Wrong address</td>
</tr>
<tr>
<td>cel</td>
<td>xxxx</td>
<td>xxxxxxx</td>
<td>1b</td>
<td></td>
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</tr>
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<td>xxxxxxx</td>
<td>1b</td>
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<tr>
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<td>5a</td>
<td></td>
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</table>

Source: Catherine M. Pallozzi, CHAM, CCS, director of patient access, Albany (NY) Medical Center. Reprinted with permission.
Q&A from CMS

FAQs about the new ABN

Now that your facility may be using the new Advance Beneficiary Notice (ABN) of Noncoverage form, which becomes mandatory March 1, 2009, and is also known as the ABN-R-131, it is a good time to answer some of your questions. The following are CMS’ FAQs about the revised ABNs:

What changes have been made to the current ABN?

The following are some key features of the revised ABN. The new form:

- Has a new official title, “Advance Beneficiary Notice of Noncoverage,” to more clearly convey its purpose
- Replaces the existing ABN-G and ABN-L forms
- May also be used for voluntary notifications in place of the Notice of Exclusion from Medicare Benefits form
- Has a mandatory field for cost estimates of the items/services at issue
- Includes a new beneficiary option under which an individual may choose to receive an item/service and pay for it out of pocket, rather than have a claim submitted to Medicare

Where can the revised ABN and instructions for completing the form be accessed?

The revised ABN and form instructions can be accessed online at www.cms.hhs.gov/bn.

(Note: You can also download the revised form through HCPro, Inc., at www.hcpro.com/content/210789.pdf and get instructions from the Patient Access Resource Center at http://accessresourcecenter.com/content/210790.pdf.)

May the revised ABN be translated into other languages?

The ABN is an Office of Management & Budget–approved form and cannot be altered, except as permitted by the accompanying instructions.

Notifiers should choose the appropriate version of the ABN based on the language the beneficiary best understands.

When Spanish-language ABNs are used, the notifier should make insertions on the notice in Spanish. For beneficiaries who speak languages other than English or Spanish, verbal assistance in other languages may be provided to help beneficiaries understand the notice. Notifiers should document any translation assistance that they provide in the “Additional Information” section of the notice.
Sample patient access scripting

Editor’s note: These patient access scripts are used by Skagit Valley Hospital in Mount Vernon, WA, and are reprinted with permission.

1. Introduce yourself to each patient by stating, “Hello, my name is __________. I am a member of the care team, and I’m going to register you for your services today.”

2. For safety, verify the patient’s name and date of birth by stating, “Would you please spell your name for me? What is your date of birth?”

3. Ask open-ended questions. Do not approach the registration by asking, “Has anything changed?” Instead, phrase your questions to elicit more complete information. For example, obtain address information by stating, “Could you please verify your mailing address for me?”

4. Ask for the patient’s insurance card by stating, “We need your card to verify eligibility for this date of service. I will scan it so we can verify your coverage quickly the next time you visit.”

5. When you put the identification bracelet on the patient, it is necessary, for safety, to verify the patient’s name and date of birth by stating, “Is your name __________, and is your date of birth __________?” even though you have just registered the patient.

6. Upon completion of the registration process, ask the patient, “Is there anything else I can do for you at this time?” Then state, “Thank you for your time. Another member of the care team will be with you as soon as possible.”

By following the above scripting, you will set the stage for a compassionate patient experience.