Certified Healthcare Access Associate

2011 Study Guide

National **A**ssociation of **H**ealthcare **A**ccess **M**anagement
2025 M Street, NW, Suite 800
Washington, D.C. 20036
(202) 367-1125
Fax: (202) 367-2125
E-mail: info@naham.org http://www.naham.org

Dear CHAA Candidate,

It's 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 on 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.

Patient access services professionals provide quality services in registration and all of its support processes to patients, providers and payors into, through and out of their health care experience. Patient access services includes: admissions, 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 RESPONSIBILITIES

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 are not able to 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 (this information is included in each examination content outline). 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.

THE CERTIFICATION PROCESS

Examinations are administered four times annually for one full month: January, April, July and October. **Applications and fees must be received a minimum of one month prior to the start of the testing month**. Test date and 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 date.

Testing will be done at a suitable location agreed upon by you and your proctor. Examination results will be sent to candidates within 8 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 is proctored. The examination is Internet-based, unless administered at a NAHAM Annual Conference or Affiliate meeting.

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 from each content area will be mixed throughout the examinations. The questions will not be presented in the order listed on the content outlines.

The following is a detailed outline of the major content areas which will be used to guide the composition of the CHAA examination effective October 2008, with an indication (in parentheses) of the approximate percentage of the test devoted to each area.

I. Pre-Encounter (40%)

A. Customer Service

1. Internal Customer Service
2. External Customer Service
3. Patient Rights and Responsibilities
4. Staff Behavior towards Customer
    a. Caring and Compassionate
    b. Technically Competent
    c. Sensitive to all Customer Needs
    d. Respect and Maintain Privacy

B. Customer Assessment

1. Age Specific Criteria and Concerns
2. Customer Expectations and Concerns
3. Clinical Concerns and Patient Needs
4. Financial Concerns and Patient Needs
5. Customer Literacy and Comprehension

C. Resource Scheduling (e.g., Equipment, Service and Staff)

1. Availability
2. Scheduling
3. Documentation
4. Communication
5. Scheduling System Applications
6. Referral Services

D. Pre-Registration

1. Registration Systems
2. Medical Record Initiation
3. Collection, Storage, and Dissemination of Patient Information
4. Respect for Patient Needs (e.g., Confidentiality and Security)

E. Patient and Family Education

1. Wayfinding
    a. Directions
    b. Parking
    c. Maps

d. Drop-off and pick-up

2. Provide Information to Customer about Assessment using Appropriate Materials and Methods

F. Prerequisites

1. Service
   a. Testing and Procedure Prerequisites (e.g., blood work, fasting or stop medication)
   b. Reviewing Service/Procedure Information with Patient
2. Financial
   a. Financial Obligations Prior to Service
   b. Regulatory Requirements
   c. Payment Programs
   d. Insurance Plans or Contracts
   e. Information Systems and/or Websites for Payors

G. Payor Authorization and/or Determination

H. Verification of Benefits

II. <u>Encounter (45%)</u>

A. Customer Service

B. Patient Check-in, Admission or Registration

1. Identification of Patient
2. Special Needs of Patient
3. Patient Placement
4. Notification and Communication of Admission
   a. Internal
   b. External
5. Level of Care (e.g., Inpatient, Observation and Outpatient)
6. Processes Related to Registering Patient
   a. Demographic information
   b. Explaining and obtaining consents, forms and signatures
   c. Insurance and payment information
   d. Physician orders
   e. Medical terminology

C. Wayfinding

1. Maps and Signage
2. Parking
3. Patient Drop-off and Pick-up Points

D. Patient Tracking

1. Locating Patient
2. Transporting Patient
3. Routing Patient

E. Census Management

1. Account for Patient Activity across Entities
2. Patient Data Interfaced with Other Systems

F. Customer Information (e.g., HIPAA Compliance on providing information)

G. Departure or Discharge

1. Collection of Patient-portion Payment

H. Billing

1. Capturing all Data Elements necessary for Accurate Billing

III. Future Development (15%)

A. Data Integrity

1. Used to measure Quality and Accuracy
2. Statistics Reporting of All Data
3. Reporting and Accessing Database

B. Resource Management

1. Staff
2. Equipment
3. Supplies

C. Customer Satisfaction

1. Survey Results
2. Quality Improvement

D. Staff Education and Competency

1. Performance Indicators
2. Performance Improvement
3. Staff Training and Continuing Education

E. Benchmarking

1. Quality of Service
2. Productivity
3. Peer Group Comparisons

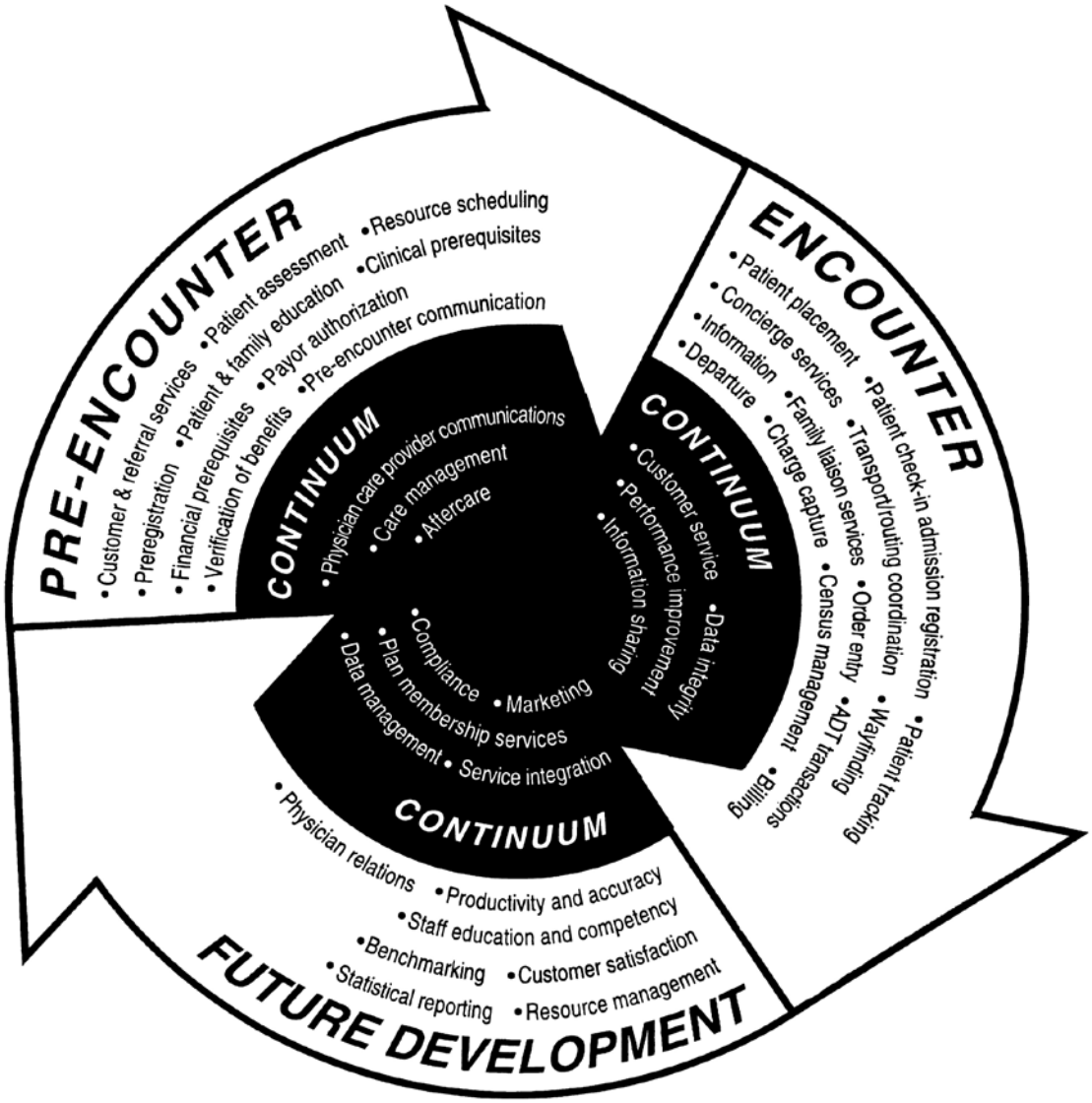
PATIENT ACCESS SERVICES OVERVIEW AND ACCESS MODEL

Healthcare Access is an integration of services that:

- Allow for accurate and completed data collection and satisfaction of prerequisites prior to a healthcare encounter (inpatient, outpatient, ambulatory care, clinic and or physician office) or at the time of an unscheduled encounter
- Ensure appropriate follow-up to assure data integrity
- Integrates the data collection necessary for financial integrity, clinical care, and discharge planning processes and continually monitors for complete and accurate data
- Provide and assure accuracy in statistical reporting
- Allow for the management of confidential communication of pertinent data throughout the continuum of care to eliminate repetitive questioning
- Encourage personalized care and service to patients, family, visitors, physicians, and other providers in the continuum of care
- Value and respect all persons who support the provision of health care service while empowering and motivating everyone to address customer needs.

Although there are structural differences between facilities and healthcare organizations, from a broad perspective, Access Services is the execution of a continuum of commonly defined functional processes that support quality care, efficiency, cost reduction, and service improvements for consumers of health services. In the past, Access Services were limited to functions related to hospital patient admissions. In many contemporary health care organizations Access encompasses a range of value added process from pre-encounter/admission, through the encounter (admission, registration, etc), and include the provision of services to assure customer loyalty. Also included are responsibilities that impact throughout the continuum of provision of health care services.

The NAHAM Access Services Model encompasses terms and explanations that provide high level information to assist in understanding the components and responsibilities of Patient access Services. The Model is divided into sections reflecting the sequence in which they commonly occur. However, there are many variations in the way healthcare provider organizations implement these components of the access cycle.



NAHAM
PATIENT ACCESS SERVICES

This model represents the execution of access through a continuum of commonly defined functional processes that support efficiency, cost reduction and service improvement.

Component	Explanation
Pre-Encounter	
Customer and Referral Services	Referral Services are the parts of the process by which patients are referred to a health care provider. The primary customers of Patient access are patients and their families, physicians, and payors 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.
Patient Assessment	The review of patients' needs and expectations for service to be provided. The review will have both a clinical and a financial focus and should include discussions about possible alternative options for care and after care planning. The review will result in the development and documentation of a plan (written and/or oral) for the patient and family.
Resource Scheduling	The receipt of a request to arrange a place, equipment and/or person(s) for a defined date and time. Includes, but is not limited to, physician appointments, ancillary services, operating room, and inpatient beds. Confirmation of availability of service and actual scheduling of service will follow the request. Documentation of the scheduled services will provide communication to all involved parties.
Pre-Registration	The collection, dissemination and storage of registration information, including demographic, financial, and clinical data, prior to the patient's arrival.
Patient and Family Education	A patient's education program is planned utilizing the results of the patient assessment. The plan includes: a determination of available materials and appropriate teaching tools and methods, the timing of the teaching and the audience (i.e. family as well as patient), age specific criteria, as well as the content/information the patient needs. Feedback is sought from the patient and family to insure comprehension and understanding.
Clinical Prerequisites	The determination of required clinical prerequisites for planned healthcare service is obtained from physician orders and other established protocols. Clinical prerequisites include, but are not limited to, preps and testing. The procedures must be communicated to the patient and/or family to insure timely completion and compliance with the requirement. Collection and review of previous testing results is required prior to the service being rendered.
Financial Prerequisites	Assuring that all the appropriate payors have been identified, their requirements have been met, and there has been communication with the patient about their financial obligations prior to service.

Payor Authorization	Approval from third party payors to provide specified care in a particular setting; written or electronic assurance that the services provided will be covered under the terms of the patient's healthcare plan.
Verification of Benefits	The process of confirming benefits for services. The process of verification of demographic, financial and insurance information that is obtained either through pre-registration or scheduling is second in importance only to the process of pre-certification. Truly, the two processes must go hand-in-hand to successfully defend the financial viability of the provider. Contact should be made with the insurance company. Benefits may vary significantly with the diagnosis. Together with pre-certification, verified coverage provides the hospital with essential information, in advance, to determine appropriate utilization review needs and alternative financial arrangements required.
Pre-encounter Communications	Oral or written information shared with patients, their families, and care providers prior to arrival for service. Includes, but is not limited to: answering questions, providing information on preparations for tests and treatments, directions, scheduling and appointment information, financial arrangements, and phone numbers to call with questions or concerns.
Encounter	
Patient Placement	The process of providing the most appropriate location and level of service 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. 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.
Patient Check-in, Admission, Registration	This can occur at any point of access in a centralized or decentralized model. All processes related to the activation of an encounter/account including: a review of demographic, guarantor, and insurance information; copying cards; obtaining consents and signatures; requesting/reviewing previous medical records; encounter summary or anything to do with the actual initiation of an encounter.

Patient Tracking	Documentation of arrival and departure to allow 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. Computer systems linked to scheduling are one approach to tracking patients. Sophisticated computerized systems that would require no additional recording of a patient's comings and goings on paper or on-line, may be the wave of the future.
Concierge Services	The term concierge, historically applied to the "doorkeeper," comes to healthcare from the hotel industry. The concept has been expanded to indicate an individual or service geared to the needs of the customer and their satisfaction. These are services rendered to make the experience of the patient and family as comfortable as possible, and go far beyond those which have been traditionally associated with a hospital stay or visit. Services that might be included: valet, comfort lounges, business centers, baggage storage and delivery, complimentary meals, reduced hotel rate, cabs, etc. Concierge services could encompass any non-clinical activity to help patients and families during an often stressful time.
Transport and Routing Coordination	Some access departments are responsible for a formally organized department of transportation, which move patients and mail throughout the enterprise. Others assume responsibility for more limited transport of patients to and from specific areas. In the broadest sense, transport and routing coordination refers to assisting patients and assuring their timely and safe arrival at correct locations. This function is linked with scheduling and patient tracking. Coordination of transportation and routing contributes to customer satisfaction through efficient service and helps ensure maximum utilization of resources (for example, care providers do not have idle time awaiting a patient.)
Wayfinding	In simple medical facilities, wayfinding may refer to a signage system that directs patients, family, and visitors to their destinations. With the growth of medical complexes and the onset of consolidation, 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, especially when they are under stress. 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 points of service, campus maps, visual cues (such as color-coding and repetitive designs,) etc.

Information	Providing information by answering direct questions as well as anticipating customers' questions. Because its meaning is familiar in non-medical contexts, patients, family, and visitors utilize Information for: directions, patient room numbers, visiting hours, locations of services, as well as other data related to the health care organization.
Family Liaison Services	All services that address the needs of patient's families or visitors within and across healthcare settings. This includes coordinated communication across settings to assure transition of family with the patient. Family Liaison Services respect patient rights, facilitate patient or family responsibilities and provide confidentiality for the patient while meeting the needs of family and visitors. Although family waiting areas and information points are prime locations, these services should span the entire continuum, assuring connectivity between physician, outpatient, ambulatory, and inpatient settings.
Order Entry	Entering orders for clinical services into the healthcare information system(s). Frequently involves some interpretation. When physicians' terminology does not match the expected standard, follow-up communications may be required (for example: physician may request a panel when Medicare requires tests to be ordered as specific analytes). Some organizations may do order entry manually by preparing a paper order form.
Patient Management System Transactions	Admission/Discharge/Transfer transactions (ADT) reflect the heart of traditional admission and bed control functions. Nearly all of today's facilities are computerized. ADT transactions record these routine patient activities on-line. They remain relevant in today's environment although the volume of patients in beds is generally decreasing as alternate methods of healthcare delivery are devised and implemented. Access management assumes responsibility for ensuring timely and accurate input of data to ensure synchronization with nursing and ancillary services systems that rely on accurate patient status and whereabouts to deliver the services they provide. Patient care may be adversely affected when correct patient ADT status is not reflected on interfaced clinical systems. Patient tracking, information, concierge services, and resource scheduling all depend on the timeliness of these transactions. CMS compliance issues, such as observance of the 3-day rule with respect to outpatient services preceding an inpatient admission, are resolved via careful attention to ADT management. Patient Management System transactions impact statistical data for census management, bed utilization, length of stay, case management and information essential to sound fiscal management.

Departure	Preparation and actual departure of patient from an encounter. Though departure planning occurs throughout the continuum of care, a smooth departure would include appropriate communication of the plan, responding to all questions, coordination of follow-up encounters, clinical instructions, pharmacy and nutrition counseling, etc. The degree or intensity of communication will be varied based upon service but should be a part of every encounter - inpatient, outpatient, ambulatory, or clinic.
Charge Capture	The process of electronically or manually applying appropriate predetermined fees associated with service delivery. This can include order entry, charge entry, verification and charge correction. The process must assure charges are accurately applied to the correct account so that the process flows effectively to billing.
Census Management	Accurate accounting of patient activity within or across entities and accurate use of data interfaced to fiscal or other statistical systems.
Billing	The process of collecting and presenting to the payor all agreed upon data elements that are necessary to secure payment for services rendered. Includes initial billing, follow-up, cash posting, and management of accounts receivable.
Future	
Statistical Reporting	Statistical reporting provides timely summarized information for process improvement, administration and management, surveys and audits, Joint Commission, requests from the legal department, etc. Reporting may be based on resources provided by health organizations' various on-line systems. It may also include custom reporting created by specialists within the department, those arranged through in-house Information Services, or an outside vendor. It is important to know what information an institution considers important in its daily activity and provide accurate input. Examining past surveys and audits may help to determine what ad hoc reporting capability is likely to be required in the future. It is important that data is saved in an accessible manner to meet federal, state, third party, and other regulatory requirements.
Resource Management	Managing resources to accommodate physician and patient needs within and across departments or healthcare settings. Incorporates responding to statistical monitors through a scheduling system to adjust for patterns of delay and responding to individual physician or patient resource needs. Appropriately engages team response for cross function problem solving.
Customer Satisfaction	Ability to provide undisputed professional courtesy, respect and confidentiality while collecting complete and accurate information. The objective measurement of the level of satisfaction as expressed by customers in relation to global processes or very specific issues.

Staff Education and Competency	Quality performance is an essential component in maintaining a patient flow that is efficient and timely and promotes high level of customer satisfaction. It is imperative that each employee knows his/her role and is skilled in the competencies required to effectively execute his/her duties. The competencies are enhanced and improved by providing staff education with specific goals and are measured by comparison to established performance standards on an annual evaluation.
Physician Relations	Coordination with physicians in the provision of care. Services provided to minimize the process steps necessary for physicians to achieve access for their patients. Education of physicians about regulatory and process requirements.
Productivity and Accuracy	The ability to professionally manage the volume of patient registrations while maintaining the desired level of data collection quality. Performance measurements having defined standards that are regularly monitored and reported. Appropriate improvement actions are taken.
Benchmarking	Formal comparison of the quality of service, productivity, customer satisfaction and/or costs with similar functional groups to improve process or performance.

ACROSS THE CONTINUUM

Some Access components are not readily segregated into Pre-encounter, Encounter, and Future Development processes. Instead they span the continuum of care. These include:

- Physician/Care provider communications
- Care Management
- Customer Service
- Data Integrity and Management
- Performance Improvement
- Information sharing
- Compliance
- Marketing
- Plan membership services
- Service integration

Although these topics have been covered in a particular section of the Study Guide, in actuality, they may appear numerous times in any portion of the Access process.

Pre-Encounter

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. Attitude is a state of mind or feeling that reflects a person's disposition in relation to another person, thing, or situation. A behavior is an action/reaction, or a role under specified circumstances; the way we conduct ourselves. Customers have a perception of our attitude based on our behaviors. When access staff imagines them or their loved ones receiving healthcare services, it helps keep patient relations in the forefront of their mind and encourages constructive behavior. Patient access services customers are both internal and external.

Internal Customer Service

In healthcare access services, internal customers include other departments within the healthcare facility as well as fellow employees including management. Meeting expectations of internal customers involves providing clear and accurate communication through verbal and written documentation to ensure a clean claim is processed. Information Services is a vital internal customer and key to ensuring that adequate software and hardware is available to optimize performance in access services. Demonstrating excellence in customer service to internal customers sets a positive impression for those external customers, primarily the patient.

Internal Customer Service is the mechanism for addressing all questions, concerns and/or complaints raised by the customers. In order to ensure that all customers have their concerns and complaints addressed in timely manner staff members will listen to the customer who raises a complaint, question or concern. A customer may be any patient, family member, visitor, physician or other hospital personnel.

External Customer Service

External customers include the patient, physicians, visitors, third party payors, suppliers etc. Service may be provided face to face, via phone or in writing. Providing service excellence to external customers is vital to ensure a positive healthcare experience for all patients. Demonstrating compassion is as significant as competence in assuring a clean and accurate claim is generated. Ensuring wait times are kept to a minimum shows respect not only for the patient but the physician who is waiting to perform the necessary procedure. Third party payors and suppliers are dependent on exceptional customer service through accuracy and accountability to ensure claims are processed timely and materials are delivered in accordance with need and supply.

External Customer Service is the mechanism for addressing all questions, concerns and or complaints raised by external customers (i.e. a physician's office, lab, insurance company or agency). In order to ensure that all customers have their concerns and complaints addressed in a timely manner, staff members will listen to the customer who raises a complaint, question or concern.

For either an internal or external customer complaint, the staff member will encourage the customer to address the following questions:

- What is the problem?
- What has the customer attempted to do to correct the problem?
- What would the customer like to see as an outcome?

Here is an example of how a customer complaint might be resolved:

- Customer complaints are submitted in writing to the Manager who will follow-up in the manner most appropriate, and make every effort to resolve the problem at the unit level.
- Confer with customers by telephone or in person in order to obtain details of complaints.
- Keep records of customer interactions and transactions, recording details of inquiries, complaints, and comments, as well as actions taken.
- Resolve customers' service or billing complaints by performing activities such adjusting bills as appropriate.
- Check to ensure that appropriate changes were made to resolve customers' problems.
- Contact customers to respond to inquiries or to notify them of claim investigation results and any planned adjustments.
- Refer unresolved customer grievances to designated departments for further investigation.
- Determine charges for services requested, collect deposits or payments, or arrange for billing.
- Obtain and examine all relevant information to assess validity of complaints.
- If the customer feels that the issue remains unresolved, the customer will be given the opportunity to contact the hospital Patient Relation's department. The manager will then confer with Patient Relations regarding the customer complaint.
- Patients always have the right to contact the Patient Advocate.
- In the event of a complaint the Manager records the complaint in a complaint log and keeps these on file.

Customer complaints should be noted and every effort should be made to resolve the problem at the unit level. If the complaints cannot be resolved at the unit level then they are submitted in writing to the Manager who will follow-up in the manner most appropriate and who will confer with the appropriate department.

<u>Patient Rights and Responsibilities</u>

It is everyone's responsibility to know your facility's policy and procedures addressing the rights and responsibilities of all patients receiving care. The safety of healthcare delivery is enhanced when patients, as appropriate to their condition, are partners in healthcare processes. Educating patients regarding their rights and responsibilities will serve to enhance the safe delivery of care, treatment and services.

Recognize that each patient is an individual with unique healthcare needs, and be committed to assisting each patient to exercise their rights in determining their own care decisions.

In accordance with state and federal laws and accrediting agencies, each facility and its medical staff have identified and are committed to observing Patient Rights and Responsibilities. These rights and responsibilities shall be provided to patients upon admission.

Patients will receive information in a manner and language they can understand. Written materials will be printed in a minimum of 12 point font unless otherwise required by regulation. Patient Rights will be posted for patient and staff visualization in key locations throughout the facility.

All personnel providing services to patients and families are responsible for knowing, promoting and assisting patients to exercise their rights.

Staff should ask the patient if he or she would like the facility to provide the patients' next of kin or agent under a power of attorney for healthcare with materials regarding patient's rights and responsibilities.

When patients and or family indicate that they have a need to have their rights and/or responsibilities clarified or have questions, staff members should contact their facilities designee to assist the patient. Depending on the hour and/or condition of the patient, consider notification of your supervisor, a nurse, or the operations supervisor.

Staff Behaviors

Compassion is as significant as competence in creating a positive healthcare experience. A common sense approach is useful in patient relations. By engaging in the following behaviors, healthcare employees create a positive impression.

- Smiling, making eye contact, calling patients by their preferred name, allowing visitors and patients to enter the elevator first all demonstrate respect and compassion
- Explaining procedures, guidelines and why things are happening and offering help when someone looks confused help reduce stress
- Limiting conversations in hallways and elevators and other public areas aids in assuring privacy
- Accepting responsibility for problem resolution and providing a professional appearance demonstrate competence.
- 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.

Communication

Communication is the process by which messages are transmitted. 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% is tone of voice and 55% is body language.

Patient Access staff members need to exhibit a high level of communication competency. First, it is important to understand the basis of communication:

- There is a message to be sent
- There is a person to send the message
- There is a person to receive the message

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.

What is communication?

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

Verbal Communication is the initial form of communication. It is words or language. There are three (3) steps to communication:

- *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.

- *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).

- *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.

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 include:

- 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 or paraphrase what has been said. It is ok to write down important information so you will remember it later.
- Repeating back the patients questions or concern
- Paraphrasing the patient’s remarks in your own words
- Ask questions
- Be patient

One technique that can be effective follows:

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

Patient Communication Techniques include:

- Open ended questions: questions that require patients to make their own response; not just yes or no but detailed information
- Reflecting: asking the patient to repeat what they have heard to ensure understanding
- Paraphrasing: restate what you heard in your own words; 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 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.

Responding to an Angry Patient

People in healthcare encounters may feel vulnerable and experience a sense of a loss of control, and may react with anger. Anger could be physical or emotional. Not only could the patient be in physical pain but they may also be concerned about the financial implications of their illness or condition.

Diffusing a volatile situation can be difficult. It involves patience, tact and diplomacy. Never respond to an angry patient with anger. It is never ok to yell or swear at a patient regardless of what the patient may say. By talking calmly and slowly you demonstrate that you are listening and that conveys your concern and care to the patient. Be honest. You may not be able to fix the problem but you can make sure that the person who can assist the patient is available and alerted. Do not belittle the problem. It may not be a big deal to you but it is important to the patient and that makes it a big deal. Do not offer reassurances to the patient, like, "it's ok Mrs. Smith, it's probably nothing."

Unfortunately, you do have to be concerned about your own safety and the safety of other patients and staff if the angry patient is also aggressive or combative. Your own office policies should address this type of situation and how the physician employer wants specific situations to be handled.

Technically Competent

Staff should be technically competent and have a high level of knowledge and skill related to the area they are working in. For instance, people who perform registration should be able to:

- Ask the appropriate question for completing registration and insurance verification
- Answer the patient's questions as they relate to registration and billing
- Complete the registration process with a high level of accuracy

Technical competence encompasses those skills and knowledge to ensure care is provided in an environment where staff is accountable:

- Be able to use problem solving skills
- Have the knowledge and skills of human interaction
- Have the ability to form collaborative relationships among caregivers, patients, patient's family, and community members.

Sensitivity to Customer Needs

Being sensitive to customer needs is often measured by the patient's perception of whether or not staff members made an effort to understand their unique situation. Meeting personal requirements for each patient is important in achieving customer/patient satisfaction.

We sometimes forget and become impatient when a patient may not be able to function in a normal manner. We become short and expect them to act as a healthy person, not being sensitive to the fact that they are here for health problems. Patients want others to understand that they have not always been sick or incapacitated. They have, in the past, been able to do for themselves, however, need staff to be sensitive to the fact that during this period of time they need someone to be sensitive to their needs.

Being sensitive to patients needs is an affirmation made to the patient by the health care staff that says, “Yes, you are sick and I understand that you are not able to do the things you would like to do, or have done in the past.” We should, at all times, help when we can and understand that they are the one who has been inconvenienced by their illness.

Tips:

- Creating patient centered environments that are sensitive to patient needs is highly correlated with the likelihood that a facility will be recommended by a patient. Patients will be more likely to return and remain loyal to your facility if they feel that staff is proactively catering to their personal needs.
- Continuously develop active listening and empathic communication through practice and training. Allow patients to tell their story or information they feel is necessary for their visit. In other words, treat the patient the same way you would expect to be treated if the roles were reversed.
- Always remember that patients are our customers and deserve to be treated with respect and sensitivity. They would not be here unless they needed a healthcare professional or procedure.

Respect and Maintain Privacy

Patient privacy protections are part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA included provisions designed to encourage electronic transactions and also required new safeguards to protect the security and confidentiality of health information. The final regulation covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions (e.g., enrollment, billing and eligibility verification) electronically.

Provide the patient with the information regarding your facilities Patient Privacy Practices.

This also means treating the patient with respect, speaking privately (unless the patient requests a family member be present) with the patient in an area that cannot be

overheard and in a language understood by the patient. Ensure a translator is available if needed.

Speak to the patient's level of understanding. Using technical terms or speaking "down" to a patient leads to poor customer service.

Customer Assessment - Age Specific Criteria

Special care is taken to address the specific needs of all patients. Registration and scheduling personnel, as well as other access staff, are required to be competent on age-specific considerations including knowledge of growth and development and the ability to obtain and interpret information on patient needs. Listed below are examples of cognitive and psychosocial characteristics, and tips for interacting with patients in some age groups.

Age Group	Cognitive	Psychosocial	Tips
School Children	− questions "Why?" − knows address & phone # − short attention span	− increasing independence − learns appropriate social manners − fears loss of control, the unknown, bodily injury	− involve in conversation − allow child to have some control − keep explanations simple − keep waiting times to a minimum
Late childhood/ adolescents	− enjoys learning − able to discuss problems − conceptual as well as concrete thinking	− peers are important − fears loss of control, bodily injury	− observe body language as a cue for feelings − allow & respect normal expressions of emotions such as crying or anger − provide clear, concise explanations − encourage questions
Adults	− at peak of mental abilities − verbal skills − information recall − reasoning	− health concerns − many responsibilities including children and aging parents	− calm, pleasant approach − maintain eye contact − provide privacy − consider role or culture and lifestyle
Seniors	− decreased memory − slowdown in ability to process information	− increased concern for health − retirement − death of spouse and friends	− identify self, repeatedly if necessary − address by title (Mr., Mrs., etc.) and last name, not first name − speak distinctly − provide privacy & reduce distractions

Customer Expectations

In healthcare access services, customers include physicians, other departments and fellow employees, visitors, third party payors, etc. Patients are very special healthcare customers. 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. However, according to a Press-Ganey study, staff empathy has a major impact on a patient's impression of a hospital. Patients may put up with marginal amenities; however, they have low tolerance for impersonal or uncompassionate care. Patients expect that:

- All healthcare workers and volunteers are caring and compassionate
- Employees are knowledgeable and keep them and their families/friends informed about procedures, test, treatments, etc. according to HIPAA guidelines.
- Staff members are technically competent
- Healthcare workers are sensitive to the inconvenience and stress that result from health problems
- Privacy is protected and their individual needs are anticipated and fulfilled
- Staff communicates with them using terms and language they can understand.

Clinical Concerns and Patient Needs

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 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

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. We respect the medical needs of all people who come to our 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.

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 are familiar with the benefits, limitations and coverage of their health insurance plan. 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. Offer payment arrangements if appropriate as established by your facility.

Customer Literacy and Comprehension

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.

Patients should demonstrate an understanding to 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.

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

RESOURCE SCHEDULING

Availability

It is vitally important to coordinate with the individual departments to assist them in maximizing their department productivity by managing their schedule 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 availability of services and know what referral options are available in your community for service 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 available to help them. Keep them

updated if things change.

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 if prior approval is necessary
- 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 – if 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.

This will improve patient satisfaction, staff satisfaction, and be a more effective use of time.

Documentation

- Advise patients to bring any required documentation to their appointment (insurance cards, identification, physician referrals, etc)
- Ensure the services scheduled are the services reflected on the physician order and the order is present and compliant before services are rendered.
- 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.
- In many cases, it is useful to note special circumstances on the schedule with the patient's information. Examples: "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 alternate 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.

Do's

- 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.

Communication

Often times your interaction with the patient is brief and you need to cover a lot of information. You have less time but you still need be an effective communicator. The answer is to communicate "smarter" by making better use of the time you have. To communicate smarter with your patients, you will need to refine the basic communication skills you already have. You can make the necessary adjustments in your communication style to accommodate today's more participatory style of care, and take steps to go the extra mile.

Basics Skills

To master basic communication skills you should listen empathetically. You should pay attention to nonverbal behaviors. Always try to give well-reasoned explanations. Do not take shortcuts as too often they may be taken in the wrong places and may weaken the patient relationship you have worked so hard to build. In addition, it may keep you from obtaining crucial information necessary to your patients' care. To maintain the quality make sure you are doing all those things you already know you are supposed to be doing.

Do not omit the pleasantries. Along with other benefits, it is widely known that patients are more likely to follow advice if they have a good relationship with you. Therefore,

anything you can do to build rapport is not just a nicety -- it is an essential part of patient care.

- *Do not appear rushed, even if you are*. Patients are greatly irritated when you appear hurried. It is important to make each patient feel that he or she is the only one that matters right now and you listen intently.
- *Keep conversations on track*. Helping the patient stay on track is key to increasing efficiency and maximizing the value of the time you have with them.
- *Listen without interrupting*. While your tendency may be to ask your patients many questions up front, you will get more information and save time in the end by actively listening to the patient without interrupting.
- *Relate with your eyes.* Avoid spending the entire patient visit focusing on a computer screen; be sure to look into the patient's eyes. Your eye contact should be direct should be sincere and convey interest. If you need to write things down you can use words like “that is very important, let me write that down.”
- *Organize your interviews.* Be sure to ask open-ended questions, seeking clarification, using reflective phrases and avoiding statements that might evoke defensive responses.
- *Make an extra effort to build trust.* It is important to establish at least this level of comfort with all. Doing this the first time will show your patients that they can count on you. Doing it again and again will build trust.
- *Be aware of changing dynamics.* Take some time to analyze your own interactions with patients. Patients who were able to ask questions and offer opinions about the treatment process were found to have measurably better outcomes.
- *Empower your patients.* Even though many patients prefer a more participatory role in their health care, you will continue to encounter some patients who may find you intimidating. Encourage the patient to ask questions and be involved in their treatment.
- *Manage patient expectations.* It is important to manage patients' expectations about their experience and treatment. Be prepared for patients with a long list of concerns.
- *Provide more information in less time.* Even though people today are inundated with information about their health, they still want more. One way to provide more information to your patient through printed education materials.

<u>Going the Extra Mile</u>

Even after you have refined and adjusted, your style, there is still more you can do to meet -- and exceed -- your patients' expectations.

- Do the unexpected
- Communicate
- Follow up
- Walk the talk – it is one thing to talk about excellence, it is another to provide it.
- Help the patient’s with their questions or refer the patient to the appropriate staff
- <u>Do</u> what you <u>say</u> you will.

The Benefits

The single most important criterion by which patients judge you is the way you interact with them. The way they judge you is also the way they judge the facility. It is therefore vital that you develop your understanding of your own communication style and adjust that style to meet the needs of various patients.

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 used the following basic information will most likely need to be reflected on the scheduling grid:

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

PRE-REGISTRATION

Registration Systems

As with scheduling systems, registration systems vary from facility to facility, but primarily require similar information, which usually includes (but is not necessarily limited to):

- Patient name
- Date of birth
- Address
- Phone number
- Alternate/mailing address
- Alternate contact information
- Employment status
- Employer information
- Religious preference
- Advanced directive information
- Next of kin information
- Insurance information
- Service type
- Service location

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 (ten) 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.
- A patient's medical record is to always to be protected from any unauthorized review.

Respect for Patient Needs

In addition to gathering data necessary to assess the patient's ability to pay, other essential data is vital to caring for the patient. Obtaining special request such as needs for a translator, special equipment, dietary requirements, etc. at the point of pre-registration enables timely referrals to social services and initiation of discharge planning.

- Admitting diagnosis may indicate need for: 'reverse air flow' (RAF) or 'positive air flow' (PAF) room;
- Continuous monitoring; specialty bed or equipment, etc.
- Requires foreign language interpreter
- Utilizes TDD phone at home or patient support person must use TDD phone.

The goal of the patient rights and organization ethics function is to help improve patient outcomes by respecting each patient's rights and conducting business relationships with patients and the public in an ethical manner.

- Patients have a fundamental right to considerate care that safeguards their personal dignity and respects their cultural, psychosocial, and spiritual values.

These values often influence patients' perception of care and illness. Understanding and respecting these values guide the provider in meeting the patients' care needs and preferences.
- A hospital's behavior towards its patients and its business practices has a significant impact on the patient's experience of and response to care. Access, treatment, respect, and conduct affect patient rights.

The standards on the Patient Rights and Organizational Ethics address the following processes and activities:

- Promoting consideration of patient values and preferences, including the decision to discontinue treatment
- Recognizing the hospital's responsibilities under law
- Informing patients of their responsibilities in the care process
- Managing the hospital's relationships with patients and the public in an ethical manner.

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, developmental, cultural and religious practices, emotional barriers desire/motivation to learn, physical/cognitive limitations, language barriers and 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.

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 day of 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 a seriously ill family member.

CLINICAL PREREQUISITES

Service

Once the appropriate appointment has been scheduled and reiterated with the patient you should advise them of any pre-appointment “do’s and don’ts” or pre-appointment

requirements. These requirements should be determined by the department but might include the following examples:

- “It is important that on the day of your screening mammogram you do not use any lotions, powders or deodorants as their presence may interfere with an accurate test.”
- “On the day of your pulmonary test, avoid using an inhaler prior to your test if at all possible.”
- “Your lipid panel is a “fasting” blood test. This means you should have nothing to eat or drink except water for at least 8 hours prior to your test.”
- “Take you prescribed medication or use your prep kit according to directions prior to your appointment.”

Reviewing Service and Procedure Information with the Patient

After the patient has been advised of any pre-appointment requirements you should review the service/procedure with the patient so they know what to expect and possibly minimize anxieties the patient may have regarding their upcoming services. Always remember to keep the conversation within the scope of your position and do not discuss clinical information beyond what is scripted for you by the department.

Some examples of what you might review with a patient:

- “You should plan for your test to take about XXX minutes to complete”
- “Some patients find our pulmonary lab a little chilly. Blankets are available, but you might want to bring a sweater”
- “Since you cannot wear any deodorant, powder or lotions on the day of your mammogram you might like to know we provide single-use deodorant towelettes for you to use, should you wish, after your test has been completed
- “Your stress test requires you to walk for up to 30 minutes on a treadmill. You will want to make sure you wear comfortable walking shoes”

FINANCIAL CLEARANCE

Financial Obligations for Scheduled Services

This could also be called "financial pre-determination", 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.

It is very important that the patient understand their financial obligation or their portion of the estimated bill prior to providing services. This will ensure that patient is not “surprised” by their portion of the bill and promote good customer service. This may also be a good time to collect the co-pays or ask for a deposit for larger expected out of pocket expenses.

Point of Service Collection

Point of service collection means collecting the patient's portion of the bill at the time service is rendered. When registering scheduled patients, they 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 Payors – 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 co-pays 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 patient in determining if they qualify for any of the under-insured/uninsured programs.

Regulatory Requirements

Emergency Medical Treatment and Active Labor Act (EMTALA) - EMTALA is a Federal Law enacted in 1986 by the Centers for Medicare and Medicaid Services to protect patients against discrimination based on his or her economic status and mandates patients receive screening exam and stabilizing treatment when seeking emergency medical care or is in active labor.

We are not allowed to discuss a patient's insurance, finances or accept payment prior to the patient receiving medical screening exam and stabilization. We cannot discuss these matters with friends or family members until the patient is stabilized.

Prior to a patient receiving a medical screening exam we can ask if he or she has insurance and take a copy of the card but we cannot discuss coverage or payments until the patient has been stabilized. We cannot accept payment prior to treatment even if the patient or family volunteers.

Violations of this law could result in fines and lawsuits.

Regulatory Agencies

Joint Commission on Accreditation of Healthcare Organizations (TJC) - The mission of the Joint Commission is to improve the quality of health care for the public by providing accreditation and related services that support performance improvement in health care organizations. The Joint Commission evaluates and accredits more than 18,000 health care organizations in the United States, including hospitals, health care networks, managed care organizations, and health care organizations that provide home care, long term care, behavioral health care, laboratory, and ambulatory care services. The Joint Commission is an independent, not-for-profit organization, and the nation's oldest and largest standards-setting and health care accrediting body.

The Board of Commissioners is the Joint Commission's governing body, providing policy leadership and oversight. Board members have diverse experience in health care, business and public policy. Direct links to the current health care environment enable board members to guide the Joint Commission in developing state-of-the-art evaluation services.

The published Standards for Hospital Accreditation in 1953 and began offering accreditation to hospitals. When Congress passed the Medicare Act (1965) it included a provision that hospitals accredited by the Joint Commission are "deemed" to be in compliance with most of the Medicare Conditions of Participation for Hospitals and, thus, able to participate in Medicare and Medicaid. Hospitals are charged a fee for this “voluntary” survey process. Without accreditation, hospital may not participate in Medicare and Medicaid programs. In 1970, the standards were rewritten to represent optimal achievable levels of quality, instead of minimum essential levels of quality and registered nurses and hospital administrators joined physicians in conducting accreditation surveys.

When the Social Security Act was amended in 1972, it included a requirement that Secretary of the U.S. Department of Health and Human Services (DHHS) validate Joint Commission findings. The law also required the Secretary to include an evaluation of the Joint Commission's accreditation process in the annual DHHS report to Congress. Reflecting its expanded scope of activities, the Commission changed its name to Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1987. There was a new emphasis on actual organization performance. 1993 saw the beginning of the re-organization of The Accreditation Manual for Hospitals around important patient care and organization functions shifting the focus from standards that measure an organization's capability to perform to those that look at its actual performance.

The Commission has established standards for psychiatric facilities, alcoholism and substance abuse programs and community mental health programs, ambulatory and managed care and long-term care organizations, hospice and home care, for health care networks, and for preferred provider organizations and labs. Professional and Technical Advisory Committees were established for each accreditation program.

By asking for accreditation, an organization agrees to be measured against national standards set by health care professionals. An accredited organization substantially complies with Joint Commission standards and continuously makes efforts to improve the care and services it provides.

Health care organizations seek Joint Commission accreditation because it:

- Enhances community confidence;
- Provides a report card for the public;
- Offers an objective evaluation of the organization's performance;
- Stimulates the organization's quality improvement efforts;
- Aids in professional staff recruitment;
- Provides a staff education tool;
- May be used to meet certain Medicare certification requirements;
- Expedites third-party payment;
- Often fulfills state licensure requirements;
- May favorably influence liability insurance premiums;
- Favorably influences managed care contract decisions.

Specially trained surveyors evaluate each health care organization's compliance with Joint Commission standards and identify the organization's strengths and weaknesses. The surveyors' goal is to provide education and consultation so health care organizations can improve, as well as identifying issues of non-compliance.

The report that accompanies each accreditation decision is a valuable educational resource. It details those areas where an organization's performance must improve and includes recommendations for how to meet the standards. Typically accreditation is a three-year cycle; the Commission conducts mid-cycle, random, unannounced surveys on accredited organizations across the nation. If a health care organization has some problems, JCAHO may award accreditation contingent on those problems being fixed in a reasonable amount of time. Organizations with more substantial deficiencies are monitored closely to make sure they are working to resolve the issues.

Compliance

The Office of the Inspector General (OIG) states that compliance is a dynamic process that helps to ensure that hospitals and other health care 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. Through a voluntary compliance program, hospitals under the direction of the designated hospital compliance officer, will be able improve the quality of patient care, substantially reduce fraud, reduce of waste and abuse, and reduce the cost of health care to federal, state

and private health insurers.

Seven levels of minimum requirements for an effective compliance program include:

1. Establish compliance standards, procedures and policies
2. Assign oversight responsibility for compliance to an individual high in the organization's structure
3. Conduct effective training and educational programs (communications of standards)
4. Perform internal audits and continued monitoring to detect noncompliance and improve quality
5. Develop effective lines of communication for reporting violations and clarifying policies
6. Enforce standards through well-publicized discipline guidelines and procedures
7. Respond appropriately and immediately to detected offenses in order to prevent further offense though corrective action.

Components of the establishment of compliance standards, procedures and policies are:

- Code of Conduct
- Admission Policy
- Discharge Policy
- Patient Referrals
- Physician Agreements
- Claim Development
- Home health Agency Policy
- Private Benefit/Increment Issues
- Government Investigations
- Screening employees/Independent Contractor

Components of performing internal audits and continued monitoring to detect noncompliance and improve quality are:

- Hotline and Post Office Box
- Auditing Systems
- Filing Systems
- Document Retention
- Annual Assessment

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Initially components of HIPAA focused on the new 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. The HIPAA regulations come under the jurisdiction of the Department of Health and Human Services (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 is protected.

Administrative Simplification rules include:

- Standards for Privacy
- National Provider Identification
- Transaction and Code Sets
- Employer Identification
- Security and Electronic Signature

The following information is extracted from HHS web site on administrative simplification. See http://hhs.gov/admnsimp for more detailed information.

Standards for Privacy
The maintenance and exchange of individually identifiable health information is an integral component of the delivery of quality health care. In order to receive accurate and reliable diagnosis and treatment, patients must provide health care professionals with accurate, detailed information about their personal health, behavior, and other aspects of their lives. Health care providers and payors rely on the provision of such information to accurately and promptly process claims for payment and for other administrative functions that directly affect a patient's ability to receive needed care, the quality of that care, and the efficiency with which it is delivered. However, patients want to know that their sensitive information will be protected not only during the course of their treatment but also in the future as that information is maintained and/or transmitted within and outside of the health care system.

Reasons for Increased Concerns About Individually Identified Health Information:

- Privacy standards vary greatly from state to state – no standardized privacy policies
- Rapid growth of integrated health care delivery systems requires greater use of integrated health information systems.
- Greater use of electronic data has also increased the ability to identify and treat

those who are at risk for disease, conduct vital research, detect fraud and abuse, and measure and improve the quality of care delivered in the U.S.
- Use of electronic information has helped to speed the delivery of effective care and the processing of billions of dollars worth of health care claims.

The establishment of a consistent foundation of privacy standards requires the increased and proper use of electronic information while protecting the needs of patients to safeguard their privacy.

These standards will help to restore patient confidence in the health care system, providing benefits to both patients and providers. The ease of information collection, organization, retention, and exchange made possible by the advances in computer and other electronic technology afford many benefits to the health care industry and patients. At the same time, these advances have reduced or eliminated many of the logistical obstacles that previously served to protect the confidentiality of health information and the privacy interests of individuals. Electronic technology does allow for the establishment of audit trails that were not as reliable as information stored on other media.

Training

Covered entities must provide training on their own policies and procedures related to protecting health information. Each entity is required to provide:

- Initial training to all employees who are likely to have contact with protected health information by the effective date of that particular rule
- Training to new members of the workforce within a reasonable time period after joining the entity.
- Retraining to those members of the workforce whose duties are directly affected by a policy change within a reasonable time of making the change.
- A statement for the trained employee to sign certifying that he or she received the privacy training and will honor all of the health organization's privacy policies and procedures.
- Each member of the workforce with a new statement to sign at least every three (3) years certifying that he or she will honor all of the entity's privacy policies and procedures.

The Privacy Rule permits certain incidental uses and disclosures that occur as a by-product of permissible disclosures as long as the health care entity applied reasonable safeguards and implemented the minimum necessary standard.

The health care entity must have appropriate technical and physical safeguards in place to protect against unauthorized disclosures. The health care entity is not expected to guarantee the privacy of PHI from any and all potential risks. The safeguards should not cause a potential risk to patients by not having information available to those needing it and should not cause an excessive financial and administrative burden to the institution.

Reasonable Safeguards may include:

- Speaking quietly when discussing a patient's condition with family members in the waiting room or other public areas
- Avoiding using patient names in public hallways and elevators and posting signs to remind employees to protect patient confidentiality
- Isolating or locking file cabinets or record rooms
- Providing additional security on computers that maintain personal information

Health care entities must also have policies in place that limit how much protected health information is used, disclosed and requested for certain purposes. These minimum necessary policies should be based on job duties and limit employee access to PHI to what is actually needed. The employee should only be granted access to the level of detail of PHI needed to do the job.

Information Services

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

They provide:

- Integrated support for all departments within entire health organizations
- Identify patients or records uniquely
- Automated functions in the financial, clinical, and administrative areas
- Improve patient care
- Obtain reimbursement for services rendered
- Easier access to clinical and administrative data
- Save time by automating tasks which would other wise require staff time and attention

The functions of an Information Services (IS) Department in a healthcare organization may include:

- 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 use of hardware and software systems
- Integrating data and process to provide value-added information
- Advising, monitoring, and ensuring data integrity through analysis and support.

Technical Information

A basic understanding of how information systems work is important to all access center staff. Computer systems are comprised of hardware and software.

- Hardware includes: keyboards, monitors, central processing units (CPU), servers, printers, cables and cords, etc.
- Software includes: systems programs that make the computers run (operating systems such as Windows and DOS), application programs (registration program) and interfaces.

Hot Spots, function keys and icons are all shortcuts to other pathways, functions or programs and 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 it could be a problem with the program (software). The more access associates know about the computer systems they use, the more they will be able to trouble-shoot on their own or more easily explain the problem to the information technology (IT) staff so it can be identified and resolved.

Software Applications

Typically Access Associates enter data in 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 pre-scheduled 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.

Healthcare Systems

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

Master Patient/Person Index (MPI)
An MPI will uniquely identify:

- The health system's entire patient population
- Store key identifying data on each patient

Although the identifying data will vary from one organization to another, an enterprise wide MPI will store at least all medical record numbers associated with that entity's clients. The volume and kind of data stored will also vary – from a simple list of identifiers to a compilation of all registration data on an individual, including insurance and financial information and some basic clinical information.

Clinical Data Repository (CDR)
A CDR provides ready access to information from a variety of sources within a healthcare delivery network. Typically clinical data from ancillary services (lab, radiology), nursing, physicians, etc. will be integrated into a single long-term record for the patient. These repositories also may provide the ability to trend analysis such as graphing results of lab values, etc.

Payment Programs
Healthcare options: Each state has programs to help the under-insured/uninsured with medical expenses. The U.S. uninsured Help Line was launched two years ago initially to help the estimated 6.8 million uninsured Californians get coverage. Getting the word out has been primarily through radio and newspaper public service announcements, articles and word of mouth through the health care, social services and insurance broker communities.

The organization's "Coverage for All" campaign tools include the following:

- The free U.S. uninsured Help Line (800)-234-1317 provides live, one-on-one assistance and is staffed 24/7 with friendly information
- Specialists and interpreters who speak multiple languages, provide basic screening for both public and private health coverage, help callers identify their potential options and connect them to health
- Coverage representatives to sign-up for coverage
- The 5-Question Eligibility Quiz online tool at http://www.coverageforall.org provides visitors with a customized profile of all public and private health coverage options in the U.S. for which family members may qualify.
- One example of how the uninsured are being helped is The Health Care Options Matrix (available for all 50 states), outlines public and private health coverage options, including type of coverage, eligibility, and monthly costs.

Prescription Options

The Partnership for Prescription Assistance is a national program to help patients in need get access to prescription medicines. More information can be found at https://www.pparx.org/Intro.php.

General Insurance Information

Health insurance is “coverage” for medical expenses a patient could incur as a result of illness or injury. Patients may buy or opt for this coverage (personally or through an employer) to insure themselves against significant monetary loss.

Insurance policies may have different levels of coverage. Some policies may pay at 100%, while another may pay 80%, leaving the insured to pay the remaining 20%. Other policies have deductibles that the insured must pay before the insurance will pay; or there may be co-pays the insured must pay at the time of service. Insurance policies may also differ in the “benefits” they offer. A benefit is coverage for a certain type of medical condition. For example, most health insurance policies offer inpatient hospitalization and outpatient doctor and surgery benefits. However, many policies do not provide prescription or experimental surgery as a benefit. The policies may differ in the coverage provided for the benefits. For example, inpatient and outpatient surgery services may be covered at 100%, but benefits for mental health or substance abuse may be paid at 75%.

Guidelines for Determining the Policyholder

The policyholder (or subscriber) is the person who contracts with the insurance company for health care coverage. The policyholder may or may not be the person whose name appears on the card. To determine the policyholder, use the following guidelines:

- For most Blue Cross, Commercial, and PPO (Preferred Provider Organization) insurance the policyholder is the person whose name appears on the insurance card
- Most HMOs (Health Maintenance Organization) give each insured person his or her own card. In this instance the person on the card may be the patient, but the patient may not be the policyholder. The patient must be asked who the policyholder is on the insurance.
- For most HMOs, the policyholder can be identified by a two-digit suffix of 00 or 01. Spouses are usually identified by a subsequent number such as 01 or 02, and dependents with 03, 04 and so forth.
- For Tricare (formerly known as Champus/Champva) insurance the policyholder will be the sponsor or the person who is active or retired from the military.
- For Medicare, Medicaid, the policyholder will ALWAYS be the patient.
- For Workers Compensation the policyholder is usually the employer.

Centers for Medicare and Medicaid SERVICES (CMS)
(Formerly known as the Health Care Financing Administration - HCFA)

The name reflects the emphasis at the Centers for Medicare & Medicaid Services on responsiveness to beneficiaries and providers, and on improving the quality of care that beneficiaries receive in all parts of Medicare and Medicaid. Three business centers exist within CMS:

- Center for Beneficiary Choices
- Center for Medicare Management
- Center for Medicaid and State Operations

CMS is a federal agency within the U.S. Department of Health and Human Services. CMS was created on March 9, 1977 to consolidate into one agency the responsibility for administering the largest federal health programs, Medicare and Medicaid. CMS also works with the Health Resources and Services Administration to run the Children's Health Insurance Program (CHIP), a program for uninsured children in the United States.

CMS' mission is to assure health security for its beneficiaries. The agency's vision is to lead the Nation's health care system toward improved health for all. CMS goals are:

- Protect and improve beneficiary health and satisfaction
- Promote the fiscal integrity of CMS programs
- Purchase the best value health care for beneficiaries
- Promote beneficiary and public understanding of CMS and its programs
- Foster excellence in the design and administration of CMS's programs
- Provide leadership in the broader public interest to improve health.

CMS functions include:

- Assures that the Medicaid, Medicare and Children's Health Insurance programs are properly run by its contractors and state agencies
- Establishes policies for paying health care providers
- Conducts research on the effectiveness of various methods of health care management, treatment, and financing
- Assesses the quality of health care facilities and services and taking enforcement actions as appropriate.

Quality Assessment and Performance Improvement
Quality improvement is based on:

- Developing and enforcing standards through surveillance
- Measuring and improving outcomes of care
- Educating health care providers about quality improvement opportunities
- Educating beneficiaries to make good health care choices.

Health Standards and Quality

CMS is responsible for implementing federal quality assurance standards in laboratories, nursing homes, hospitals, and home health agencies as well as in ambulatory surgical centers, hospices and other facilities that participate in the Medicare and Medicaid programs. State inspection teams working under agreement with CMS conduct surveys of health care providers and suppliers to ensure compliance with federal standards for health, safety and quality of care. Follow-up inspections are performed when necessary to bring facilities into compliance.

CMS' "Health Care Quality Improvement Initiative" emphasizes systematic assessment of patterns of care and patterns of outcomes for beneficiaries. CMS, in partnership with other quality-focused organizations such as Peer Review Organizations (PROs) and End Stage Renal Disease (ESRD) Network Organizations, is engaged in numerous national projects aimed at improving the processes and outcomes of care for beneficiaries. Some projects include:

- Diabetes Quality Improvement Project (DQIP)
- ESRD Clinical Performance Measures (CPMs) Project
- Healthy Aging Project
- Medicare Health Outcomes Survey (HOS)
- Medicare Quality of Care Surveillance System
- Quality Improvement System for Managed Care (QISMC)

Peer Review Organization (PRO)

CMS administers the Peer Review Organization (PRO) program, which is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of fifty-three PROs (also known as Quality Improvement Organizations) responsible for each U.S. state, territory, and the District of Columbia. PRO mission is to ensure the:

- Quality
- Effectiveness
- Efficiency
- Economy of health care services

PROs perform two principal functions:

- Conduct Cooperative Quality Improvement Projects - designed to improve the quality of care delivered to Medicare beneficiaries through examining and improving processes of health-care delivery.
- Provide Beneficiary Protection and Education through mandatory case review including review of beneficiary complaints, and outreach activities such as health promotion and disease prevention campaigns.

Efficiency and Fiscal Integrity in Health Care

CMS leads the health care industry in the use of electronic technology for all phases of claims processing, reducing administrative costs. A national Medicare Transaction System is one of the requirements under HIPAA that should bring even greater efficiency to the processing and payment of claims and better serve the information needs of consumers and providers.

Payment Programs

In 1992 CMS began paying physicians according to a national fee schedule based on the work and overhead costs associated with each medical service (Relative Value Resource Based System - RVRBS). This replaced a payment system based on historic charge patterns.

The Prospective Payment System legislated in 1983 reduced the growth rate of Medicare outlays for hospital inpatient services. This Diagnosis Related Group (DRG) system pays hospitals a fixed amount per patient based on diagnosis. Hospitals have responded by operating more efficiently, controlling costs without reducing the quality of care.

The CMS outpatient payment system called Ambulatory Payment Groups (APGs) or Ambulatory Payment Classification System (APCs) covers episodes of care for a particular medical diagnosis (excludes Behavioral Health) rather than the current system of payments for individual services.

Fraud and Abuse

CMS has a comprehensive program to combat fraud and abuse in order to protect taxpayer dollars and help guarantee security for the Medicare, Medicaid and Child Health programs. The Department of Justice (DOJ), the Office of the Inspector General (OIG) and other federal, state, and local agencies working with CMS take strong enforcement action against those who commit fraud and abuse. CMS has several initiatives to achieve savings and prevent fraud and abuse in the Medicare program. In every state, the processes used by Medicare contractors to screen claims are increasingly effective, and the contractors are required to have fraud investigators on their staffs. Funding to combat fraud and abuse is provided through the Health Insurance Portability and Accountability Act (HIPAA).

Fiscal Intermediaries and Carriers

The Social Security Act (Title XVIII) provides that public or private entities and agencies may participate in the administration of the Medicare program under agreements or contracts entered into with CMS. These Medicare contractors are known as fiscal intermediaries and carriers. With certain exceptions, intermediaries perform bill processing and pay benefits for Medicare Part A and carriers perform claims processing and benefit payment functions for Part B.

Medical Necessity

As part of their existing contractual duties, both intermediaries and carriers have been charged to perform certain program integrity activities or payment safeguard activities. These activities include:

- Conducting medical review of claims to determine whether services were medically necessary and constituted an appropriate level of care
- Deterring and detecting Medicare fraud
- Auditing provider cost reports and ensuring that Medicare pays the appropriate amount when a beneficiary has other health insurance

Under a portion of the Health Insurance Portability and Accountability Act (HIPAA), Medicare Program Safeguard Contractors will perform some or all of the activities previously performed by intermediaries and carriers. These activities include the following:

- Review of provider activities, including medical, utilization, and fraud reviews
- Cost report audits
- Medicare secondary payor determinations
- Provider and beneficiary education regarding program integrity
- Developing and updating a list of durable medical equipment that is frequently subject to unnecessary utilization in accordance with the Act.

Medicare
The federal health insurance program for:

- People age 65 and older
- People of any age with end stage renal disease
- Certain disabled people under age 65

Although most features of the Medicare program are universally applied, there is some variation from state to state for Medigap programs and in Managed Care offerings. There are also variations in the way some billing rules are interpreted from one fiscal intermediary or carrier to another.

The patient's Medicare card will identify if the patient has Part A and/or Part B and when these benefits became effective. The Medicare claim numbers are usually the patient's or spouse's social security number with a letter/number suffix or prefix. The letter code will tell how the patient acquired their Medicare benefits. The common suffixes and prefixes are:

- A - Primary wage earner
- A (prefix) - Retired railroad employee
- B - Entitled to benefits through spouse
- C – Child
- D – Widow
- D1 – Widower
- W - Disabled widow
- W1 - Disabled widower

The Original Medicare Plan is the traditional fee-for service arrangement. It is available everywhere in the United States. Medicare beneficiaries are automatically eligible and must apply 3 months before their 65th birthday.
Medicare has four parts:

- Hospital Insurance (Part A) helps pay for inpatient hospital services, skilled nursing facility services, home health services, and hospice care
- Medical Insurance (Part B) helps pay for doctor services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.
- Medicare Part C is a Medicare Advantage plan. These are private insurance companies offering plans, mostly to seniors, such as HMOs and PPOs
- Medicare Part D (Medicare Prescription Drug Coverage) helps cover prescription drugs. (This coverage may lower your prescription drug costs.)

Carriers and Fiscal Intermediaries - Private insurance organizations called Medicare carriers and fiscal intermediaries handle claims and interpret reimbursement regulations under the Original Medicare Plan.

- Carriers handle medical insurance (Part B) claims.
- Fiscal intermediaries handle all hospital insurance (Part A) claims.

Medicare Covered Services - Medicare (Part A) Hospital Insurance helps pay for necessary medical care and services furnished by Medicare-certified hospitals, skilled nursing facilities, home health agencies, and hospices.

Inpatient Hospital Care - Medicare Part A helps pay for up to 90 days of inpatient hospital care in each benefit period. Covered services include semi-private room and meals, general nursing services, operating and recovery room costs, intensive care, drugs, laboratory tests, X-rays, and all other necessary medical services and supplies.

Pre-admission Diagnostic Services - Medicare's three day (AKA: 72 Hour) Rule requires that pre-admission testing and diagnostic services provided to a beneficiary by the admitting hospital within three days prior to the admission are included in the inpatient payment. They are not to be billed as separate outpatient charges unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, services provided by the hospital on Sunday, Monday, or Tuesday are included in the inpatient Part A payment. This provision includes visits to the Emergency department but does not apply to ambulance services.

Benefit Periods - The number of days that Medicare covers care in hospitals and skilled nursing facilities is measured in benefit periods. A benefit period begins on the first day of services as a patient in a hospital or skilled nursing facility and ends 60 days after discharge from the hospital or skilled nursing facility provided that 60 days has not been interrupted by skilled care in any other facility. There is no limit to the number of benefit periods. The beneficiary must pay the inpatient hospital deductible for each benefit period.

Life Time Reserve Days - Medicare will pay for an additional 60 days of hospitalization when a beneficiary is an inpatient in a hospital for greater than 90 days. The 60 days can be used only once in a lifetime. For each lifetime reserve day, Medicare pays all

covered charges except for the daily co-insurance.

Important Message from Medicare (IMM) - 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.

Skilled Nursing Facility Care - If medically necessary, Part A helps pay for up to 100 days in a participating skilled nursing facility in each benefit period. Medicare pays all approved charges for the first 20 days; patients pay a coinsurance amount for days 21 through 100. Covered services include semi-private room and meals, skilled nursing services, rehabilitation services, drugs, and medical supplies.

Home Health Care - If medically necessary, Medicare pays the full-approved cost of covered home health care services. This includes part-time or intermittent skilled nursing services prescribed by a physician for treatment or rehabilitation of homebound patients. The only amount patients pay for home health care is a 20 percent coinsurance charge for medical equipment such as a wheelchair or walker.

Hospice Care – (Not covered by a Senior Medicare HMOs) assists with care for terminally ill beneficiaries who select the hospice care benefit. There are no deductibles, but beneficiaries pay limited costs for drugs and inpatient respite care.

Medicare (Part B) Medical Insurance - Helps pay for doctors services, outpatient hospital services (including emergency room visits), ambulance transportation, diagnostic tests, laboratory services, some preventive care like mammography and Pap smear screening, outpatient therapy services, durable medical equipment and supplies, and a variety of other health services. Part B also pays for home health care services for which Part A does not pay.

Medicare Part B pays 80 percent of approved charges for most covered services. Beneficiaries are responsible for paying a $100 deductible per calendar year and the remaining 20 percent of the Medicare approved charge. Patients will have to pay limited additional charges (15 percent over Medicare's approved amount) if their physician does not accept assignment. The limiting charge only applies to certain services and does not apply to supplies or equipment.

Medicare Part C Insurance – Medicare beneficiaries can elect to assign their Medicare benefits to a private insurance company that has special coverage for seniors usually an HMO or PPO.

Medicare Part D Insurance - (Medicare Prescription Drug Coverage) helps cover prescription drugs. This coverage may lower your prescription drug costs. Medicare's open enrollment is from November 15 to December 31, 2007. People with Medicare can enroll in a drug plan, review their health care and drug coverage, and make changes. There's even extra help available for people with limited income and resources. The extra help is worth up to $3,600 for some people to help pay for their drug coverage.

It is important to remember that all people with Medicare can complete their yearly Medicare Enrollment Review November through December and make changes so ask!

Medicare Non-Covered Services

Except for certain limited cases in Canada and Mexico, Medicare does not pay for treatment outside the United States.

Medicare Part A - Does not pay for convenience items such as telephones and televisions provided by hospitals or skilled nursing facilities, private rooms (unless medically necessary), or private duty nurses. The only type of nursing home care Medicare pays for is skilled nursing facility care for rehabilitation, such as recovery time after a hospital discharge. Medicare does not pay if the beneficiary needs only custodial services (help with daily living activities like bathing, eating or getting dressed).

Medicare Part B - Usually does not pay for most prescription drugs, routine physical examinations, or services not related to treatment of illness or injury. Part B does not pay for dental care or dentures, cosmetic surgery, routine foot care, hearing aids, eye examinations, or eyeglasses.

Advance Beneficiary Notice (ABN) - A notice that a care provider should give a Medicare beneficiary to sign in the following cases:

Medicare may not consider the health care services being provided as medically necessary; there is a good possibility that Medicare will not pay for the service provided and the patient may be billed for this service.

If the ABN has not been signed before service is rendered and Medicare does not pay for it, the patient cannot be held responsible for paying for that service. If the ABN was signed, the patient may be billed for the services.

Many Fiscal Intermediaries are using software that compares the diagnosis (ICD9 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.

Medicare as Secondary Payor (MSP) – there are specific situations where another insurance is primary and Medicare is the secondary payor. Some people who have Medicare have other insurance (not including Medigap policies) that must pay before

Medicare pays its share of the bill. An MSP questionnaire should be completed on all Medicare patients each time a service is provided to assure that appropriate billing guidelines are followed remembering that this information can change from visit to visit. Failure to comply with completing this information can result in fines.

Medicare is the secondary payor if:

- Patient is 65 or older and is covered by group health insurance which is provided by an employer, with 20 or more employees, for whom they or their spouse is currently working
- Patient is under age 65 and disabled, they or any member of their family is currently working at an employer with 100 or more employees, and they are covered by group health insurance based on that employment
- Patient has Medicare because of permanent kidney failure – end stage renal program (for the first 30 months; Medicare becomes the primary payor after 30 months)
- Patient has an illness or injury that is covered under workers' compensation, the federal black lung program, no-fault insurance, or any liability insurance.

During the intake process, when a beneficiary cannot recall his or her precise retirement date but knows it occurred prior to his or her Medicare entitlement dates the entitlement date can be used as the retirement date.

If the beneficiary worked beyond his or her Medicare Part A entitlement date and cannot recall the precise date of his or her retirement but you determine it has been at least five (5) years since the beneficiary retired you may enter a date of five (5) years back from the date of service as the retirement date.

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 onto the one account) you are required to verify the patient's MSP information every 90 days to insure the information is current and update as needed

<u>How Medicare Pays</u>
To avoid excessive inpatient stays, Medicare pays fixed amounts to hospitals according to the patient's diagnosis. Medicare pays the Diagnostic Related Grouping (DRG) rate regardless of the actual hospital charges or length of stay.

Medicare categorizes the patient's stay into a DRG, which determines the base payment the hospital will receive. These base payment rates are comprised of a standardized amount. Hospitals could receive a higher payment or "add-on" if, for example, it serves a great percentage of low-income patients or if is an approved teaching hospital.

The payment method is important to keep in mind when a Medicare beneficiary questions the amount of the inpatient hospital bill. The Medicare payment is based on the coded diagnoses and procedures and rarely influenced by the total charges.

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 and is calculated based on the national average cost (Operating and capital) of the hospitals.

The amount the patient is responsible for, when APCs are the method of payment, will vary until the amount can be set at a standard 20% of the APC payment. This change will gradually be phased in to prevent patients from being hit with a large co-pay. However, Medicare has placed a cap on the maximum amount a patient is responsible for; their liability will not exceed the inpatient deductible amount for each outpatient service.

For other outpatient services, like Lab and Physical Therapy, Medicare pays according to a fee schedule.

Strict adherence to Medicare guidelines and regulations is required. Failure to follow these guidelines, even if unintentional, carries severe fines and penalties. In cases of fraud with intent Medicare will pursue not only the hospital, but the employee, as well.

Medicare Supplemental Insurance

There are several types of private health insurance that pay some or all of healthcare costs not covered by Medicare. Supplemental coverage includes:

- Employee coverage (from an employer or union)
- Retiree coverage (from a former employer or union)
- Medigap coverage (from a private company or group).

Medigap Insurance

Medicare supplemental insurance (Medigap) is private insurance that is designed to help pay Medicare cost-sharing amounts such as Medicare's coinsurance and deductibles, and uncovered services. Medigap Insurance must follow federal and state laws. In most states a Medigap policy must be one of ten standardized polices to help make comparison easy. Patients in Medicare Managed Care plans, or whom Medicaid covers do not need Medigap insurance; generally, it is illegal for insurance companies to sell plans to these beneficiaries.

Medicare SELECT - a type of Medicare supplemental health insurance sold by insurance companies and HMOs throughout most of the country. Medicare SELECT is the same as standard Medigap insurance in nearly all respects. The only difference between Medicare SELECT and standard Medigap insurance is that each insurer has specific hospitals, and in some cases specific doctors, that participants must use,

except in an emergency, in order to be eligible for full benefits. Medicare SELECT policies generally have lower premiums than other Medigap policies because of this requirement.

Medicare Beneficiary Notices (MBN) - an easy-to-read, monthly statement that clearly lists claims information. It replaces the Explanation of Your Medicare Part B Benefits (EOMB), the Medicare Benefits Notice (Part A) and benefit denial letters. This has been phased in across the US.

Medicare+Choice **-** provides care under contract to Medicare. These plans may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits. Medicare+Choice plans are available in many areas of the country. Medicare+Choice plans currently include:

- Medicare managed care plans like HMOs
- Medicare Private Fee-for-Service plans

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare+Choice plan manages the Medicare coverage for its members. By joining a Medicare+Choice plan, patients can often get extra benefits, like prescription drugs. The Medicare+Choice plan may have additional rules that need to be followed and an additional monthly premium for the extra benefits.

A member of a Medicare+Choice plan:

- Is still in the Medicare program.
- Must have Medicare Part A **and** Part B, and continue to pay the monthly Medicare Part B premium.
- Still gets all the regular Medicare-covered services and may be able to get extra benefits like prescription drugs or additional days in the hospital.
- Still have Medicare rights of protection

<u>Medicare Managed Care Plan Process</u>
In most managed care plans, patients can only go to certain doctors and hospitals that agree to treat members of the plan.

- Doctors can join or leave managed care plans at any time, so patients may need to transfer to another primary care physician from the managed care list.
- Patients usually need a referral to see a specialist (like a cardiologist). The primary care physician (PCP) determines if a specialist is needed. If the patient sees a specialist without a PCP referral, the patient usually has a higher co-pay.
- Patients may pay more if they seek health care outside the service area of the plan, unless there is an emergency or urgent care is needed.
- Each year, the companies offering Medicare+Choice plans can decide to join, stay with, or leave Medicare.

- Some managed care plans offer a Point-of-Service option. This allows patients to go to other doctors and hospitals who are not a part of the plan. This usually costs more, but this option gives patients more choices.

Private Fee-for-Service Process

- The private company, rather than the Medicare program, decides how much it pays, and how much the patients pay, for the outlined services.
- Patients can go to any doctor or hospital that accepts the terms of the plan's payment.
- The private company provides health care coverage to people with Medicare who join this plan.
- The private company pays a fee for each doctor visit or service. The patient may also have a co-pay.
- The private company may have a "pre-notification" requirement. For example, it may require that the patient notify the insurance carrier about any "elective" inpatient hospital admissions.
- Patients may pay more if the plan lets doctors, hospitals, and other provider's bill more than the plan pays for services. If this is allowed, there may be a limit to what the providers can charge, and patients must pay the difference.

Medicare offers more ways to receive benefits through other health plan choices. Choices that may be available depending on where the beneficiary lives include Medicare Managed Care Plans, Preferred Provider Organizations (PPO), or Provider Sponsored Organizations (PSO). In addition, Private Fee-For-Service Plans and Medicare Medical Savings Account Plans may be available. Beneficiaries opting for one of these alternatives are still in the Medicare program. All Medicare health plans must provide at least the basic Medicare covered services.

To be eligible for these other health plan choices, the beneficiary must:

- Have both Part A (hospital insurance) and Part B (medical insurance)
- Continue to pay the monthly Part B premium
- Live in the plan's service area (the counties in which the plan is offered)
- Not have End-Stage Renal Disease.

Medicare beneficiaries in managed care plans should have a membership card for the plan as well as their Medicare card. The HMO cards may indicate "Medicare HMO", "Medicare Managed Care", or something similar. Medicare HMO's still follow MSP rules for auto accidents, work-related accidents, and the working aged. For example, if a patient with a Medicare HMO has services related to an auto accident, the auto insurance MUST be billed primary.

Since patients are still Medicare beneficiaries they retain their Medicare rights and protections and receive all regular Medicare covered services. Patients must continue

to pay the Medicare Part B premium. In general, beneficiaries who are covered by Medicare due to End Stage Renal Disease are not eligible to join Medicare Managed Care Plans.

Medicaid

Medicaid was established by federal legislation in 1965 to provide health care coverage for certain low-income people. It is funded and administered through a state-federal partnership. Federal law mandates coverage of basic health care services for categories of low-income people. States have a wide degree of flexibility to design their program. States have authority to:

- Establish eligibility standards; they have the option of covering other needy people
- Determine what benefits and services to cover; they have the option to provide medical services not mandated by federal law
- Set payment rates

Qualifications:

- Certain low-income families with children
- Aged, blind or disabled people on Supplemental Security Income
- Certain low-income pregnant women and children
- Certain persons who would not otherwise be eligible but qualify as the result of catastrophic medical expenses.

Covered Services

Because states have flexibility in structuring their Medicaid programs, there are variations from state to state. All states must cover these basic services:

- Inpatient and outpatient hospital services
- Laboratory and X-ray services, skilled nursing and home health services, doctors' services
- Family planning
- Periodic health checkups, diagnosis and treatment for children

Application Process

People can generally apply for Medicaid at local welfare or social service offices. Many states have made it possible to apply in other locations, such as hospitals and public health clinics, or by mail.

Traditional Medicaid

Since all persons applying for Medicaid must meet specified financial criteria to be eligible for coverage, after a person is eligible for Medicaid coverage typically their financial status is evaluated on a regular basis. In many states, eligible persons are issued new Medicaid cards each month. The eligible dates appear on the card. In

general, the Medicaid card is issued to the head of the family. The card will list the names and recipient ID numbers for each person covered. Each Medicaid recipient will have his or her own recipient ID number.

HMO Medicaid

Medicaid contracts with HMOs are determined by the State. Healthcare organizations contract with the HMO to provide services to Medicaid recipients. Requirements for billing may vary based on the contract between that organization and the HMO. Contracts are usually arranged so the claims are submitted directly to, and paid by the HMO, which is then reimbursed by Medicaid.

Medicaid is a secondary payor with respect to Medicare.

Workers Compensation

Services that are the result of a work related accident or injuries are paid for by either the patient's employer or by the employer's workers compensation insurance company.

The employer must authorize worker compensation services. If there is no authorization, an attempt should be made to contact the employer for authorization. For billing, a claim number, or the name of the person authorizing the services is required. The patient's social security number is also required for billing. There is no card for Workers Compensation.

Key information (in additional to usual registration data) to obtain when registering a person with a work related injury/illness:

- Time and date of injury
- Type of injury
- Name of employer and contact person
- Immediate supervisor
- Employee insurance information (in case the injury is determined to not be work related)
- Enter patient classification type as 'Workers Compensation' and whom the bill should be sent to

Auto Insurance

Auto Insurance is coverage for injuries that are the result of an auto accident. Most patients that have been in an auto accident are covered by auto insurance. Rules regarding the primacy between Auto and health insurance are determined by state regulations and may vary from state to state. Whether or not there is an auto insurance card may also vary by state. Auto insurance is usually primary for all victims of an auto accident.

Guidelines for auto insurance are as follows:

- If a patient has no health insurance, then the auto insurance would be primary
- If a patient has Medicare or Medicaid as their primary insurance, and the services are the result of an auto accident, the auto insurance would be primary.
- Whenever possible, obtain the claim number, billing address, and adjuster's name and phone number.
- Verify benefits for auto insurance.

Liability Coverage

Liability coverage is for injuries that are the result of negligence of another party. For example, a patient who slipped and fell on a freshly mopped floor in a business and a sign was not posted that the floor was wet. Generally health care facilities have their own policies regarding billing for personal liability cases. Registration staff should follow the policies of their institutions. For Medicare patients, liability should be identified as a result of the Medicare Secondary Payor (MSP) questionnaire. Regulations require that liability insurance be billed prior to billing Medicare. If the liability company issues a denial, Medicare will pay on condition that liability is not established in the future. There is no “insurance card” for liability coverage.

Commercial Insurance

Insurance that is not Medicare, Medicaid, Federal, State or County Programs. Workers Compensation, Blue Cross, Auto, PPO, HMO are considered commercial insurance. Commercial Insurance companies do not require a specific contract with a provider organization to reimburse for patient services. Patients with commercial insurance are not required to select a primary care physician or to go to any specific provider. The cards for commercial insurance vary from carrier to carrier. Commercial cards usually have the following information:

- An ID number (or plan number, policy number, member number, employee number, insured number, social security number, etc)
- A group number
- There may or may not be an effective date
- The policyholder’s social security number may be required for billing

Preferred Provider Organizations (PPOs)

PPOs are contracts between employers, doctors, and hospitals. The doctors and hospitals agree to provide their services at a discount. In return, the doctors and hospitals have a volume of patients who are PPO members. These doctors/hospitals are known as participating providers. Members are not required to select a primary care physician but they must use a participating provider to obtain full coverage. If a member chooses to go to a non-participating provider/facility, their coverage decreases and they pay more out of their own pocket. There are many different PPOs and many different cards. Some cards will have the letters “PPO” on them while others do not. Healthcare facilities usually maintain a list of PPOs that the facility has contracts with available to

registration staff. Most PPO cards have the following information:

- An ID number (or member number, social security number, employee number, plan number, etc)
- An effective date
- Co-pay amounts for ER/UC and offices visits
- They may or may not have a group number

HMO Insurances

Health Maintenance Organizations (HMOs) are insurance plans that strive to control health care costs by requiring members to receive services at designated facilities. In addition, all services except those provided in life threatening situations, must be provided or approved by a participating physician. Typically members must select a primary care physician (affiliated with the HMO) who is responsible for oversight of all of the patient's health care. It is this physician who must approve any non-emergency services. An HMO contracts with specific providers/facilities.

There are many different HMOs and therefore, many different cards. Some cards will have the letters "HMO" on them and other cards do not. Most HMOs issue cards to each family member with their name and not the policyholder's name. Many HMOs have a suffix at the end of the policy number to identify the cardholder's relationship to the subscriber. For example, the policyholder's number ends in 00; the spouse's number ends in 01; the other dependent's numbers would end in 02, 03, etc. The policyholder's suffix might be 01 with 02 for the spouse and other dependents having subsequent numbers. Many HMO cards also display the PCPs name and phone number and some information about co-pays for the PCP, specialists, emergency room visits, and for prescriptions. Some HMOs specify that non-participating claims be sent to a different address than claims for participating members.

TRICARE and CHAMPVA

TRICARE is a health care program overseen by the Department of Defense in cooperation with regional civilian contractors.

TRICARE provides four options to eligible beneficiaries:

- TRICARE Prime, similar to a health maintenance organization
- TRICARE Extra, a preferred provider option that saves money for patients
- TRICARE Standard, a fee-for-service option, which is the same as the former CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services
- TRICARE for Life provides expanded medical coverage for Medicare-eligible beneficiaries

Active-duty service members are automatically enrolled in TRICARE Prime. Military Treatment Facilities (MFTs) are the principal source of healthcare. The service member's branch of service provides for the care of the active-duty service members,

or is responsible for paying for any civilian emergency care required by active-duty members.

The Civilian Health and Medical Program for the Veterans Administration (CHAMPVA) is a health benefit program for the families of veterans with 100 percent service connected disability and the surviving spouse or children of a veteran who dies from a service-connected disability. The Department of Veterans Affairs determines eligibility and processes CHAMPVA claims.

TRICARE Standard is a cost-sharing program for military families, retirees and their families, some former spouses, and survivors of deceased service members. The uniformed services covered include the Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and the National Oceanic Atmospheric Administration. The program shares the cost of most medical services from civilian providers when beneficiaries cannot get care from a military hospital or clinic. Service families are eligible to receive inpatient and outpatient care from uniformed service hospitals and clinics. The types of medical services available at uniformed service hospitals vary by facility, and hospitals serve active-duty service members first.

TRICARE Standard covers medically necessary services and supplies required for diagnosis and treatment of illness or injury, including medical care. Physicians and other authorized providers must deliver services and supplies in accordance with sound medical practice and established standards. TRICARE Standard is similar to other to other third-party payors in that there are some coverage limitations and personal financial responsibilities. TRICARE has a series of rules to determine the primary payor. In general, TRICARE is the payor secondary to coverage from another health plan (such as an HMO or a PPO). TRICARE is the primary payor if the other coverage is Medicaid, or when a patient is eligible for Indian Health Service (IHS) care and that care is obtained from a source other than HIS.

TRICARE for Life (TFL) provides expanded medical coverage for:

- Medicare-eligible retirees, including retired guard members and reservists
- Medicare-eligible family members and widow/widowers
- Certain former spouses if they were eligible for TRICARE before age 65

The patient must have Medicare Part B to be eligible for TFL. If eligible, the patient gets all Medicare covered benefits under the Original Medicare Plan, plus all TFL-covered benefits. If the patient uses a Medicare provider, Medicare will be the first payor for all Medicare-covered services, and TFL will be the second payor. TFL will pay all Medicare co-payments and deductibles and cover most of the costs of certain care not covered by Medicare.

Information Systems and/or Websites for Payors

It is usually preferable to call the number on the patient's insurance card for verification of benefits and authorization. You can verify basic insurance information via an insurance Web Site i.e. date coverage began, if the policy still active is the patient, the policy holder, or dependent, what are the deductibles and if there are co-pays for basic services. It may be preferable to speak to a representative for accurate coverage information regarding specific services and if pre-certification/pre-authorization is needed, and what, if any, are the exclusions.

If you need to use a Web Site, you can usually find an insurance company by using one of the internet search engines i.e. Google or Ask.com.

Once a Web Site has been located, they usual have a tutorial on how to use the site and information on how to sign-on.

The Common Working (CWF) is a verification system that is linked to Medicare and is a tool for verifying:

- If a patient has Part A and B coverage and the effective dates.
- Whether the patient has switched from Medicare to a Medicare Advantage plan (Part C)
- If the patient or spouse is employed and if they are covered by employee insurance.
- If the patient was ever involved in an accident where the case is still open. A third party may be responsible and not Medicare.
- The number of full and partial days remaining in the benefit period.
- The number of skilled nursing facility days remaining.
- If the patient is on hospice care.

Medicaid/ can be verified through your State's website and/or their Common Working File Verification System.

The Medicaid/ Eligibility Response normally contains important information such as:

- Scriber's ID
- Primary Aid Code
- Subscriber County: this is important, as you may need to inform the County of the patient's admission out of network.
- The Primary Care Physician Phone number: this is important in the event a referral is required
- Service Type
- Trace Number or recipient ID

General information regarding Medicaid and to see what coverage is offered in your state can be found at http://www.cms.hhs.gov/home/medicaid.asp.

VERIFICATION OF BENEFITS

The first step is calling the insurance company. This is important to verifying eligibility, since they will tell us what services are covered and if the member is currently eligible.

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 - 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.

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.

Pre-certification/Pre-Authorization – Certain insurance companies require pre-certification or pre-authorization from the Primary Care Physician (PCP) prior to services being preformed.

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% 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.

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.

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%, and the insurance company's coinsurance could be 80% 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 selects 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 payors 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 <u>not</u> 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.

<u>Coordination of Benefits</u>
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 plan are primary. The combination of state and federal laws governing the regulation of insurance plan is very complex.

When verifying benefits for dependant 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.

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
- The plan of the stepparent (spouse of the non-custodial parent)

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.

PAYOR 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 health care service that a health care 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. That is 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 health care provider; and not more costly 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.

Encounter

CUSTOMER SERVICE

Patient access is the customers' first point of contact in the healthcare encounter. Most patients enter a healthcare encounter with a wide array of emotions and attitudes about healthcare. In most instances patient access will deal with a patient who would really like to be somewhere else; yet in the course of a few short minutes, the representative must gather information to appropriately identify the patient and insure reimbursement for services, communicate required complex information to the patient regarding patient rights, HIPAA, Advanced Directives, and medical necessity, obtain consents and authorization, collect co-pays and deductibles, and direct the patient to the point of service, all while making the patient feel comfortable and important. Extensive customer service skills are necessary to complete the required tasks and provide the excellence of service required to positively impact the start of the patient's healthcare encounter.

The customer service interaction during the encounter is different than the pre-encounter interaction. During the encounter, the patient and family members can observe the patient access staff and surrounding area. First impressions are imprinted and what occurs during this important time can make or break the entire visit. Customers can observe staff behaviors and attitudes, as well as the attitudes of other patient interactions.

PATIENT CHECK-IN, ADMISSION OR REGISTRATION

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 health care system. If the patient is new to the health care 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 an 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. According to information released by the Federal Trade Commission in 2007, there were in excess of 246,000 complaints of identity theft in 2006.

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, 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 person 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.

The Joint Commission requires that hospitals establish a fall reduction program that includes an evaluation of the physical environment, staff education and training, and patient and family education. Some organizations actually require patient access to provide the patient with fall prevention education material at the point of admission. In addition, patient access should be aware of the environment and actively communicate potential hazards to the appropriate hospital department. Patient access employees who identify a potential patient at risk should communicate that information to the patient care department.

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.

Patient Placement

Patient placement is a process of providing the most appropriate location and level of service necessary for optimum clinical care delivered to the patient. Most facilities refer to this as bed control or bed management. This process 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.

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.

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.

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.

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:

- Alcohol-based hand rubs (foam or gel) 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 Centers for Disease Control and Prevention (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 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.

Notification and Communication of Admission

Organizations vary on how they process admission requests. Many facilities have a Bed Control or Patient Placement department that serves as the main point of contact for processing patient placement assignments. When a patient bed is needed, basic patient identification information is communicated to the placement department including the admitting diagnosis, admitting physician and other information required to appropriately place the patient.

The Bed Control/Placement department may also serve as the contact for external facilities and physician offices that wish to admit or transfer a patient. Some facilities have a separate Transfer Center that processes all external transfers. The external facility or physician office contacts the appropriate department and provides basic patient information including the admitting diagnosis and the on-staff physician who is accepting the patient. Facilities may require a physician order be faxed to the department before the bed assignment can be completed. The physician order would be used to determine the appropriate level of care and type of bed. Once an appropriate bed has been identified as available, the external facility or physician office is contacted and the transfer arranged.

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

Levels of Care

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 health care delivered to patients experiencing acute illness or trauma. Acute care is generally short-term (<30 days).

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 4 to 6 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 physicians order.

Recurring Services - physical therapy, occupation therapy, speech therapy, cardiac rehabilitation or pulmonary rehabilitation that occurs over time based on a clinicians 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 is an interdisciplinary team who coordinates 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.

(Please refer to the Medicare section of this manual for information about Medicare billing for Hospice.)

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.

<u>Process Related to Registering a Patient</u>

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 using open ended questions.

Explaining and Obtaining Consents (forms and signatures)
There are several types of consents that impact healthcare. These include:

- Actual or Explicit Consent
- Consent given in writing or verbally by the patient or legal representative. All verbal consents should be followed by a written consent as soon as possible.
- Implied Consent by Law
- Consent by law when a patient presents unconscious to the Emergency Department
- Implied Consent
- Referred to as consent by silence. Implied consent is the patient does not object to treatment. Note: It is always best to obtain a written consent
- Informed Consent

Consent given in writing when the patient acknowledges that he/she has been informed of the planned treatment as well as the risks involved and the risks of not having a procedure. This applies to the specific consent form for procedure(s).

In patient access, the patient or a patient representative is required to sign the consent form. This form should be explained prior to obtaining a signature and the patient or patient representative should be allowed time to review the document and ask questions. By signing this form the patient is giving basic consent for treatment. In addition, most facilities combine language in the consent form that includes a release of information for financial purposes.

The patient or patient representative must sign and date the form. Many healthcare facilities also require the relationship of the signer to the patient on the form. The patient access employee must sign as a witness after the patient or representative's signature is obtained.

If a patient's condition prevents them from signing the form and there is no patient representative available, the patient access employee may document on the form and sign as a witness. This scenario should only occur in an emergency situation where the patient's condition prevents the staff member from obtaining consent (Implied Consent by Law). In this situation it is important to follow up with the patient or patient representative to obtain a signature on the consent form (explicit consent). Scheduled, elective and walk-in services require the patient's or representative's signature. If this occurs in a non-emergency situation, and the patient is able to sign a consent form but refuses signature, services can be provided but facility-specific procedures should be reviewed for appropriate compliance. When a patient refuses to sign a consent form, management or clinical involvement may be required to address patient concerns.

Some patients are unable to sign the consent because they are incapacitated. In this situation there is usually a guardian or durable power of attorney assigned. Patient access should also obtain a copy of the guardianship or durable power of attorney

forms for the medical record as proof the individual has the right to sign legal documents on behalf of the patient.

Minors present a unique situation. Consent must be obtained from a parent or legal guardian of a minor prior to providing non-emergent services. If a minor presents for services without a parent or legal guardian, the staff member may contact the parent or legal guardian by telephone to obtain verbal consent. This needs to be documented on the consent form. Some facilities may require a second staff member to verify the verbal consent and document on the consent form as well. In some services areas, it may also be appropriate to transfer the parent or guardian to a clinical staff member to obtain required clinical information.

Minors presenting for scheduled/elective procedures without a parent or legal guardian present another challenge and supervisory and clinical involvement may be required to confirm that the necessary consents have been obtained.

In some states minors who present for the following services do not require consent from a parent or legal guardian to obtain services (verification of specific state laws and facility policies is recommended): pregnancy related services, contraceptive/Sexually transmitted disease related services, mental Health Services, substance abuse services. Also, Emancipated Minors do not need consent from a parent or legal guardian.

Emancipation is not available in every state in the United States. Where it is available, emancipation is a legal mechanism by which minors can attain legal adulthood before reaching the age at which they would normally be considered adults (this is called the “age of majority”). The rights granted to legally emancipated minors might include the ability to sign legally binding contracts, own property, and keep one’s own earnings. However, each state has different laws governing emancipation and some states simply have no law or legal process concerning emancipation.

When emancipation occurs, the emancipated minor has the ability to sign legal documents and in a healthcare situation provide their own consent for treatment. State laws govern emancipation of minors. In most states, there are three circumstances in which a minor becomes emancipated: enlisting in the military, marrying, and obtaining a court order from a judge.

In most instances, legal documentation is required as proof the minor is emancipated. Facilities may require documents to be on file prior to obtaining consent from the minor patient. These legal documents may be copied for the medical record.

In addition to the basic consent for treatment and authorization to release information for payment purposes, patient access may also be required to present additional information to the patient and obtain acknowledgement the information was explained to and/or received by the patient. Additional information may include hospital visiting

hours, smoking policy, additional services available in the facility, and other facility-specific documents.

HIPAA Privacy Notice

The Notice of Privacy Practices (NOPP) is a document that explains how protected health information (PHI) is used and disclosed by a healthcare entity. All healthcare entities are required to make The Notice of Privacy Practices available to patients and obtain acknowledgement from the patient that the information was offered. Many facilities include the Acknowledgement of Receipt of Privacy Practices in the general consent for treatment. One NOPP must be given to the patient and an acknowledgement signature obtained. This NOPP remains in effect for subsequent visits and additional Notices are not required unless the Notice changes. When there is a material revision to the Notice, facilities must distribute the new Notice to patients who receive services on or after the effective date of the revised Notice. Even if the patient received the previous Notice, the revised notice (and a new acknowledgement) must be obtained.

Patient Rights and Responsibilities/Advance Directives and Durable Power of Attorney

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 responsibility information and be prepared to direct a patient to the appropriate department for questions or concerns. In addition, staff should acquaint themselves with 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.

An Advance Directive or Living Will is written instructions regarding adult patients' wishes when they cannot make healthcare decisions for themselves.

A Durable Power of Attorney for Healthcare is the portion of the advance directive where an adult patient appoints a proxy or advocate to make medical decisions if that patient becomes incapacitated or unable to participate in his/her medical care and treatment decisions.

Although the healthcare setting is not the ideal place to initiate an advance directive, the PSDA requires that patients be educated regarding what an advance directive is and

asked if they have a completed advance directive. If a patient has an advance directive, the healthcare provider has the responsibility to place the advance directive in the patient's medical record in an identified place easily viewed by all healthcare providers.

An advance directive is activated when a patient becomes incapacitated. A person can revoke an advance directive at any time by destroying all copies.

Most healthcare organizations are emphasizing the importance of making decisions about advance directives before a person becomes ill. Organizations are providing education in outpatient settings and working with communities to co-sponsor education programs.

An Important Message from Medicare

"An Important Message from Medicare" is a form explaining beneficiary rights under Medicare and detailed instructions on how to file an appeal in the event the beneficiary disagrees with the discharge plan or has a complaint about the care they received.

This form should be explained to the patient prior to admission. The patient is required to sign the form acknowledging receipt of the form. The patient is provided the original form and a copy retained by the facility. The facility must re-present a copy of the signed form to the patient prior to discharge and provide the patient the opportunity to initiate an appeal before the discharge occurs. The form explains how the patient or patient representative can file an appeal with the designated Quality Improvement Organization (QIO).

Insurance and Payment Information

Patient access also obtains financial information from the patient. This information must be accurate and complete to insure proper claims submission to the third party payor and allow for collection of outstanding patient obligations prior to services and/or after the claim is processed.

Third Party Payor Information examples:

- Name of Payor
- Contract, policy or beneficiary identification number
- Group number if applicable
- Subscriber Name
- Subscriber date of birth
- Patient Relationship to subscriber
- Policyholder employer
- Policyholder employment status
- Claims mailing address contact information
- Customer service or insurance verification and authorization

Medicare

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans. Medicare is a Health Insurance Program for people age 65 or older, qualifying disabled

people under age 65 and patients with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant).

The amount of coverage is also dependent on whether the patient has coverage under Medicare Part A, Medicare Part B, or both. Medicare Part A typically pays for inpatient hospital expenses and Medicare Part B typically covers outpatient health care expenses including doctor fees.

Traditional Medicare (Part A/B) does not cover most outpatient prescription drugs. Medicare payments made to hospitals and skilled nursing facilities generally cover all drugs provided during a stay. Everyone with Medicare can obtain prescription drug (Part D) coverage.

Generally, patients are eligible for Medicare if the patient or their spouse worked for at least 10 years in Medicare-covered employment, is 65 years or older, and a citizen or permanent resident of the United States. The patient might also qualify for coverage if he/she has a disability or End-Stage Renal disease (permanent kidney failure requiring dialysis or transplant).

A patient can obtain Part A at age 65 without having to pay premiums if:

- He/she receives retirement benefits from Social Security or the Railroad Retirement Board.
- He/she is eligible to receive Social Security or Railroad benefits but hasn't yet filed for them.
- His or her spouse had Medicare-covered government employment.
- A patient under 65 can obtain Part A without having to pay premiums if they received Social Security or Railroad Retirement Board disability benefits for 24 months or has End-Stage Renal Disease and meet certain requirements.

While patients do not have to pay a premium for Part A under the conditions outlined above, a premium must be paid to receive Part B coverage. The Medicare card will indicate the effective dates for Part A and Part B.

All Medicare patients are required to complete a Medicare Secondary Payor (MSP) Questionnaire to determine if Medicare is the primary payor or if other third-party coverage is primary. Medicare Secondary Payor (MSP) is the term used when Medicare is not responsible for paying first. The private insurance industry uses the term "Coordination of Benefits" which has a similar meaning when determining responsibility for primary and secondary payment. The MSP Questionnaire should be completed based on the information provided by the patient or their representative for each claim. The Questionnaire asks for information needed to determine if Medicare is the primary or secondary payor, such as:

- work-related conditions / injuries
- group insurance, if the patient is age 65 or older, employed, and has coverage through a LGHP (Large Group Health Plan)
- spouse's insurance, if the patient is covered
- disability qualifications
- qualifications based on ESRD (End State Renal Disease)
- coverage based on Federal Black Lung, Veterans Administration or a Government Research Grant

Based on the answers to the Questionnaire, a determination can be made regarding the primary payor for the claim.

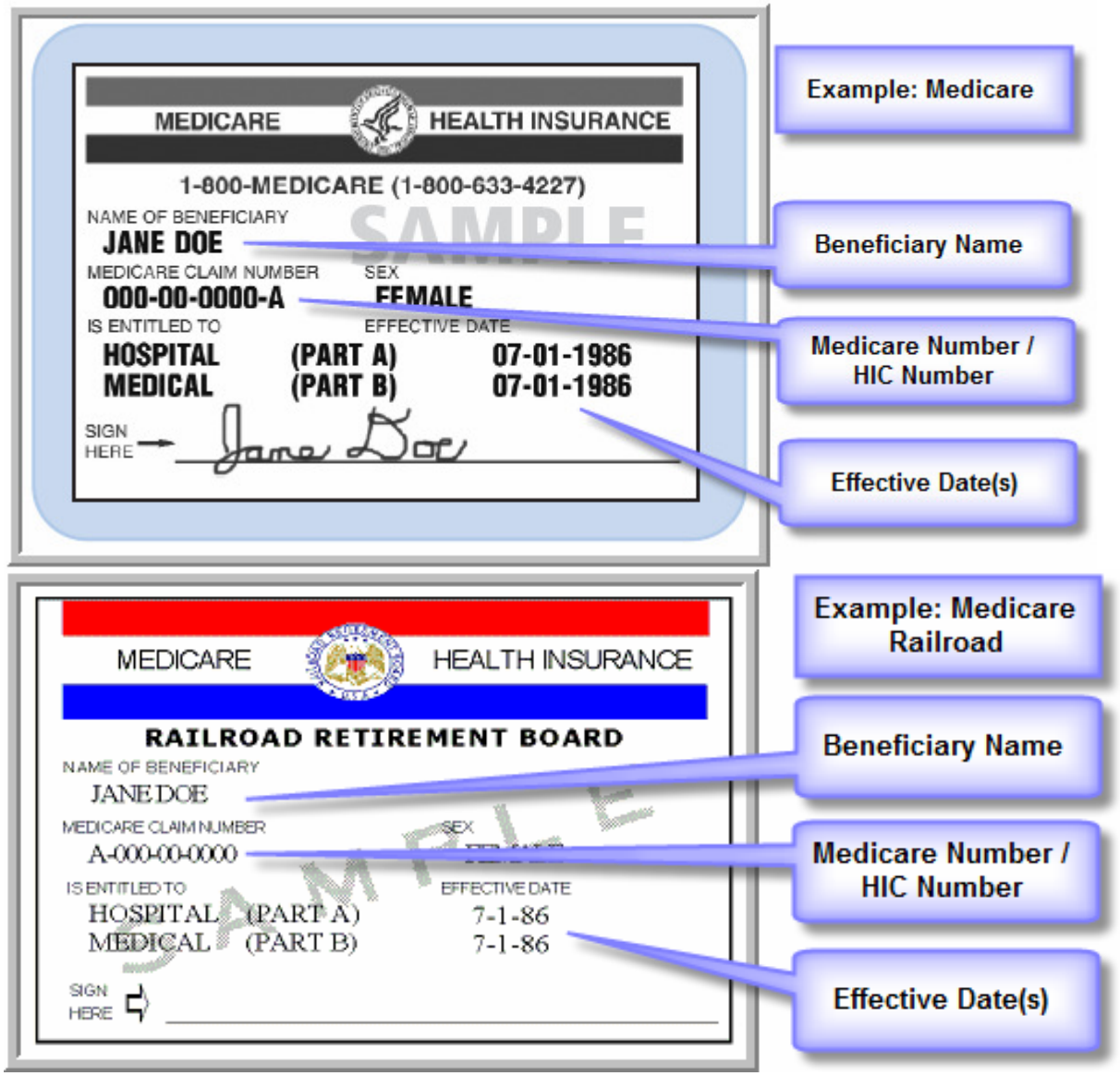
Who Pays First?

Below is an excerpt from the Medicare publication that explains MSP to the Medicare beneficiary. Patient Access gathers this type of information via the MSP Questionnaire. Additional questions are contained in the MSP.

If you	Situation	Pays first	Pays second
Are age 65 or older and covered by a group health plan because you or your spouse are still working	Entitled to Medicare	Group Health Plan	Medicare
	The employer has 20 or more employees		
	The employer has less than 20 employees*	Medicare	Group Health Plan
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Retiree Coverage
Are disabled and covered by a large group health plan from your work, or from a family member who is working	Entitled to Medicare	Large Group Health Plan	Medicare
	The employer has 100 or more employees		
	The employer has less than 100 employees	Medicare	Group Health Plan

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions. Hospital services provided for hospice care are billed separately from routine hospital services and are billed directly to the Medicare certified hospice.

Sample Medicare cards:



<u>Medicare Advantage Plans/Medicare HMO</u>
Medicare Advantage Plans are health plan options (like HMOs and PPOs) approved by Medicare and run by private companies. These plans are part of the Medicare Program and are sometimes called “Part C” or “MA plans”. Medicare Advantage Plans must follow rules set by Medicare. Medicare Advantage Plans are not supplemental insurance.

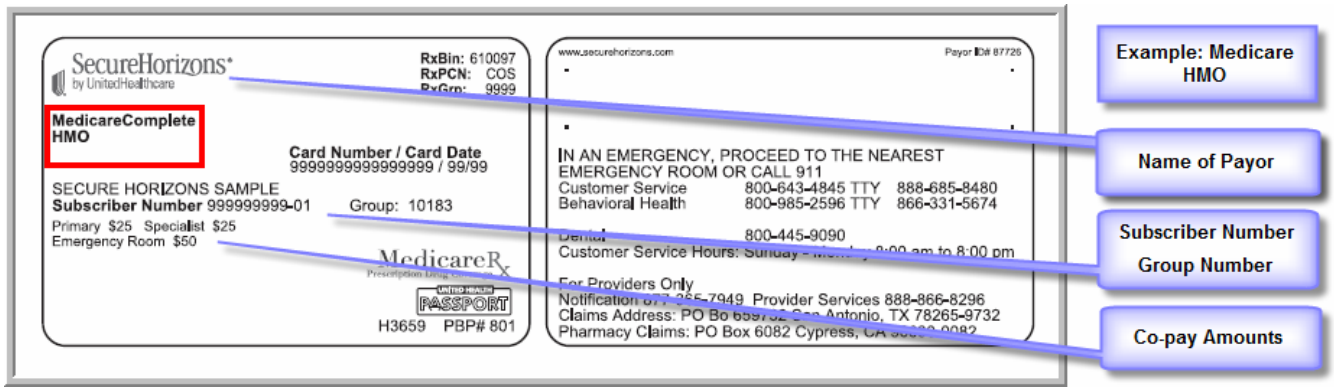
There are five different kinds of Medicare Advantage Plans. Most of these plans, like HMOs, have networks of doctors and hospitals. Others, such as Private Fee-for-Service (PFFS) Plans, allow the patient to go to any doctor if the doctor agrees to accept the plan’s terms of payment before treatment. There are also Medicare Advantage Plans called Medicare Special Needs Plans (SNPs) that serve certain people with Medicare

who are chronically ill, who live in institutions like nursing homes, or who have other special needs.

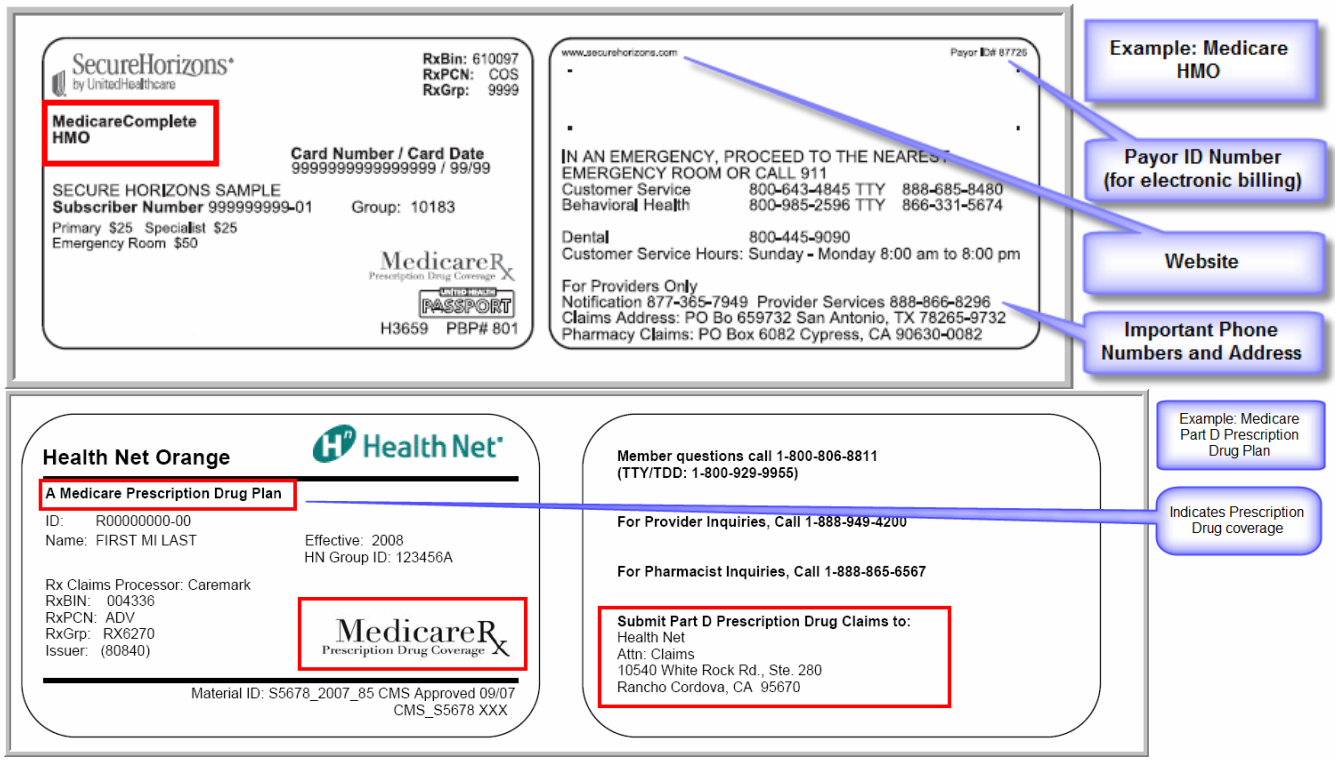
Patient access needs to be aware of the various types of plans to ensure accurate information is obtained and entered in the system for billing.

Sample Medicare HMO card:

Front of card:



Back of card:



Medicaid

Medicaid is available to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Depending on the state's rules, patients may be asked to pay a small part of the cost (co-payment) for some medical services.

Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services.

Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These requirements may include the patient's age; medical condition (pregnant, disabled, blind, or aged); income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether the patient is a U.S. citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home.

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, even for very poor persons, unless they are in one of the designated eligibility groups. Low income is only one test for Medicaid eligibility; assets and resources are also tested against established thresholds.

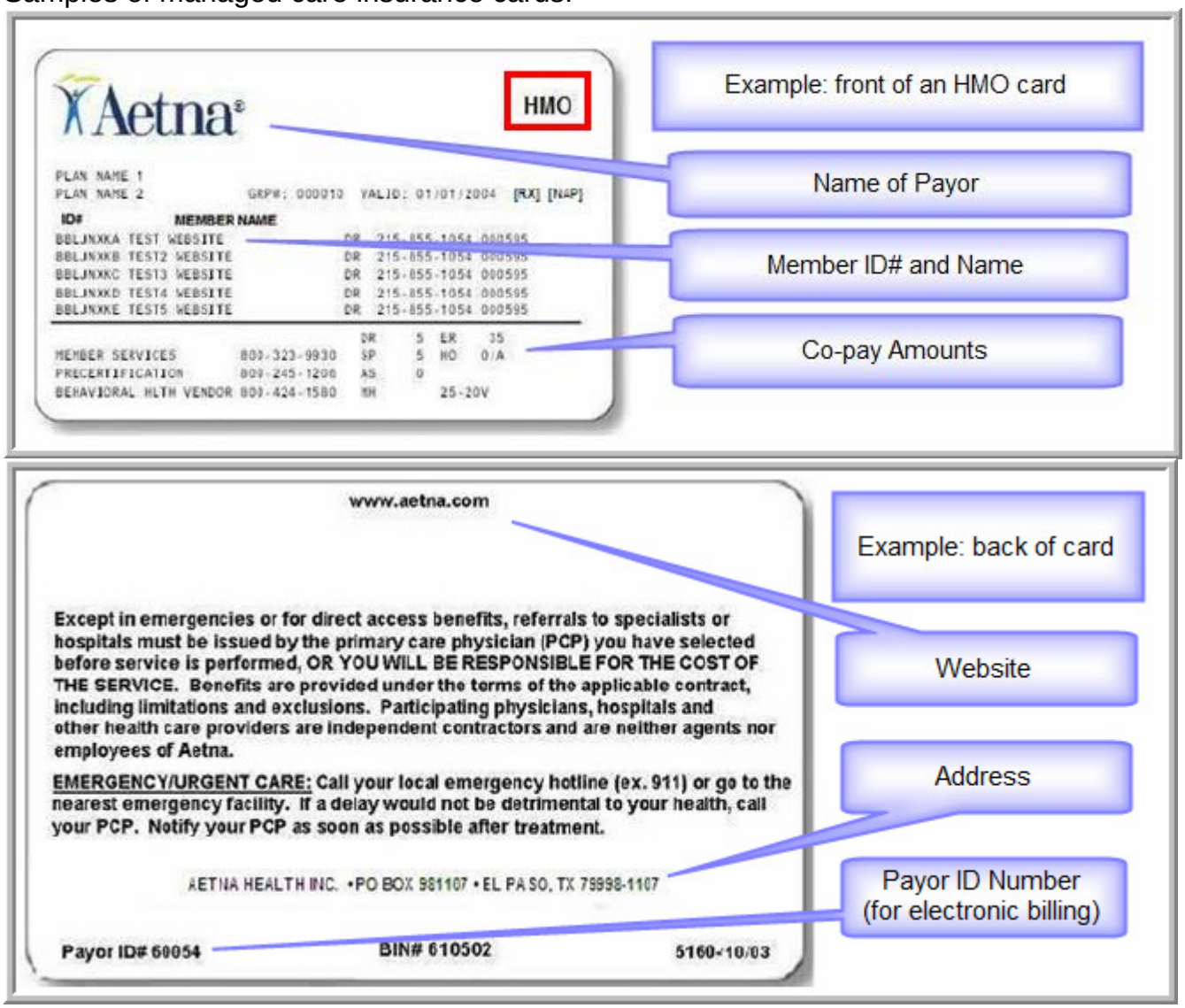
Coverage may start retroactive to any or all of the 3 months prior to application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person's circumstances change. Most states have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program.

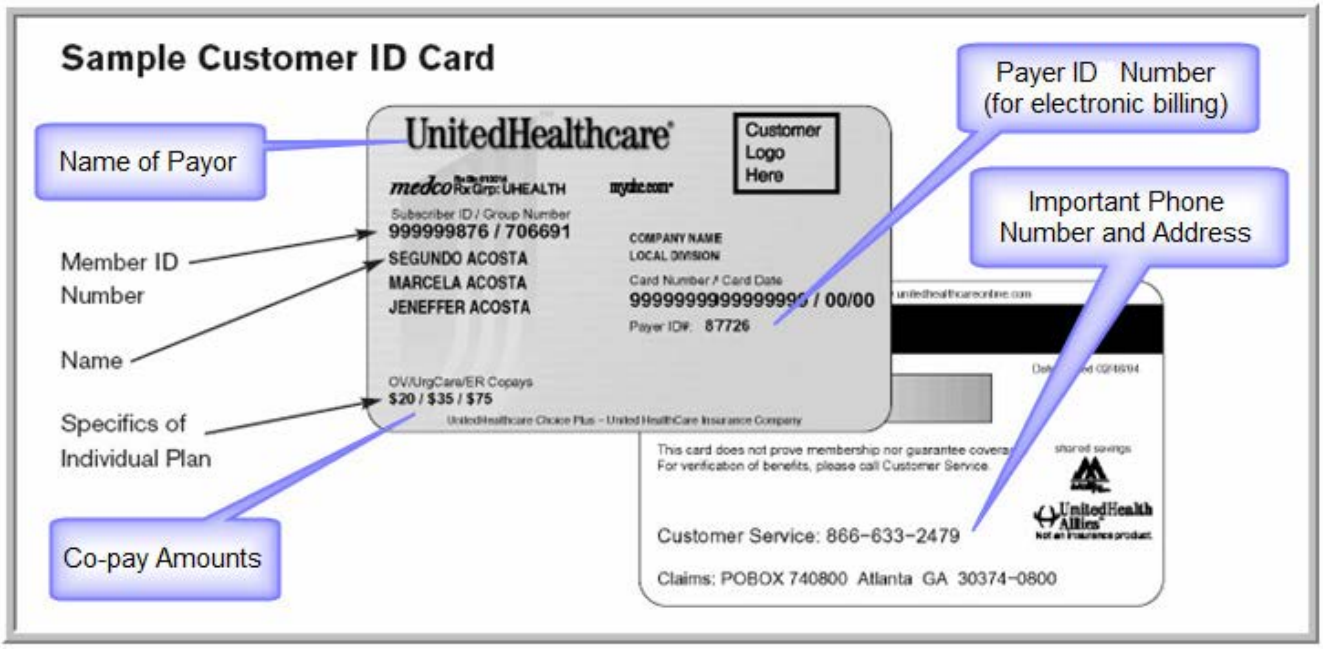
Managed Care

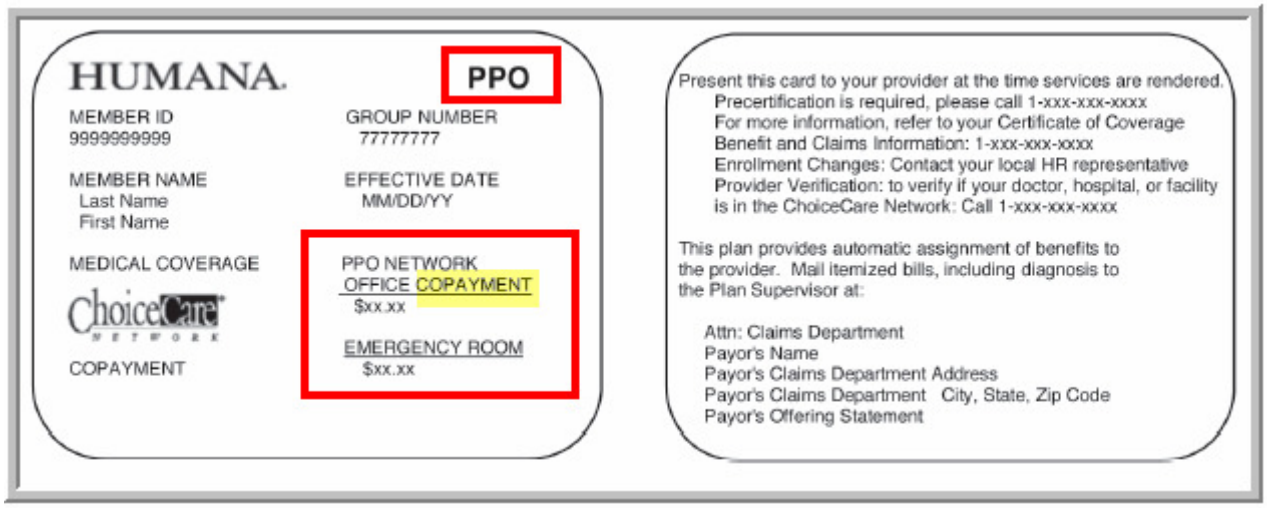
Managed care is any system that manages healthcare delivery with the aim of controlling costs. Managed care systems typically rely on a primary care physician who acts as a gatekeeper through whom the patient has to go to obtain other health services such as specialty medical care, surgery, or physical therapy.

Managed care organizations frequently contract with health care providers. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are examples of these types of contracts. Individuals insured under an HMO or PPO are allowed to receive care from the contracted providers. These providers are expected to deliver services according to specific stipulations. Payment is often subject to utilization management, in which delivery of medical services is reviewed to determine whether the services are necessary. The review may occur with each episode of treatment, or may be ongoing through the use of a case manager. If the managed care organization thinks that the services are unnecessary, payment is denied.

Samples of managed care insurance cards:







Physician Orders

A physician order is a written document that includes: patient name, procedure, diagnosis, date of service and ordering physicians name and signature. An order may be sent by fax, electronically, or given to the patient to bring to the facility. Some orders may be taken verbally by the clinical staff but specific rules apply that require verbal orders to be authenticated by the ordering physician within a specified period of time. A facility may require the physician office to provide the ICD-9 code and/or CPT code in place of a narrative. Services should not be provided if a physician order is not received for the services that require a physician order.

There are a small number of self-referred procedures which do not require a physician order. An example of a procedure that qualifies for self-referral is a screening

mammogram. Patient access employees should be aware of the various requirements for physician orders at their facility.

Medicare Medical Necessity

The Centers for Medicare & Medicaid Services (CMS) is required by the Social Security Act to ensure that payment is made only for those medical services that are reasonable and necessary. For outpatient services, Medicare requires evidence of medical necessity in order to pay for those services. Medicare has established that procedures are only medically justified for specific diagnoses as established by a Local Medical Review Policy (LMRP).

Most facilities install software designed for the purpose of checking medical necessity while other facilities check for medical necessity via a manual process. Should the diagnosis code not support the LMRP medical indications for a test or procedure, either the physician is contacted to provide additional supporting documentation or the patient is notified via an Advanced Beneficiary Notice (ABN) that the procedure or test will likely not meet the Medicare criteria for medical necessity.

The ABN is a notice given to Medicare beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance of the test or procedure that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent situations. Once the form is completed and signed, a copy is given to the beneficiary or representative and the original is retained by the facility.

Medicare guidelines will not allow providers to bill patients for non-covered services unless the patient has signed an Advance Beneficiary Notice (ABN) before the service is performed. The ABN must be specific to the services being provided and the cost of the services not covered. The Medicare patient must sign the ABN to indicate that he/she has been advised regarding non-covered items.

Facilities must keep proof of signed ABNs on file – hard copy or electronic – to satisfy Medicare requirements. Failure to produce a copy of the signed ABN for a billed claim may result in financial penalties. Charges associated with tests and procedures that are not medically justified are not reimbursable without a signed ABN. These charges cannot be written off to bad debt or charity.

Medical Terminology

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. 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.

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-9-CM) is the accepted diagnostic coding system in the United States. The ICD-9-CM classification system includes diseases, injuries, and procedures. ICD-9-CM was developed 30 years ago and has become out-dated. It cannot accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century. Therefore, an updated system, ICD-10-CM, was developed. ICD-10-CM contains an increased number of codes (from approximately 13,600 to 120,000) and categories that allow for a more specific and accurate representation of current and future medical diagnoses and procedures. An implementation date for ICD-10-CM in the United States has not been established at this time.

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.

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

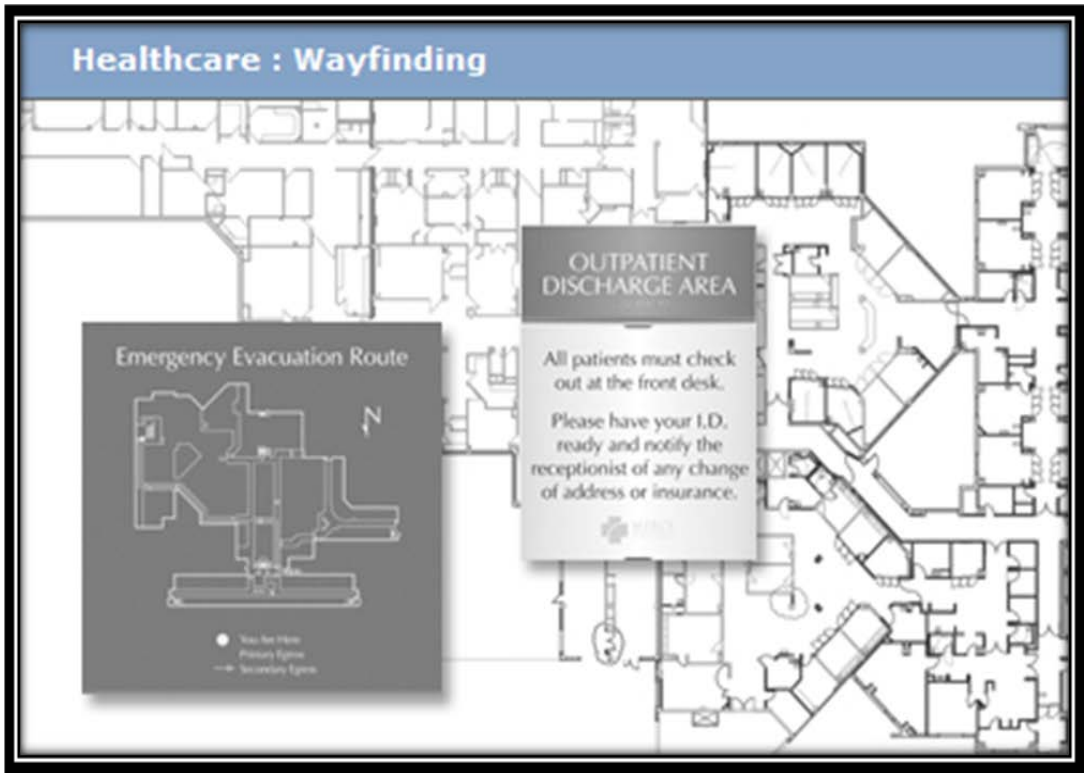
Effective wayfinding through a medical facility can help alleviate anxiety among patients and reduce strain on staff who are less likely to be needed to provide directions.

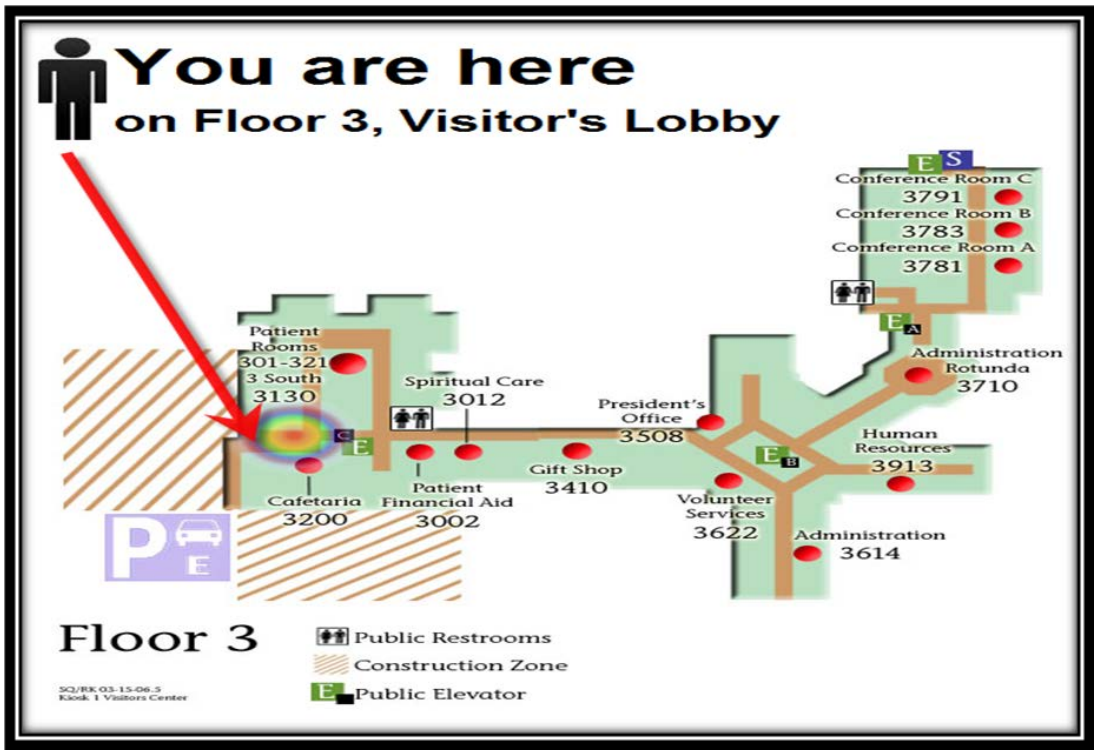
Wayfinding tools should be compliant with ADA (Americans with Disabilities Act), JCAHO and other governing agencies and regulations.

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.

Examples of wayfinding maps:





Example of a digital kiosk that displays wayfinding information:

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.

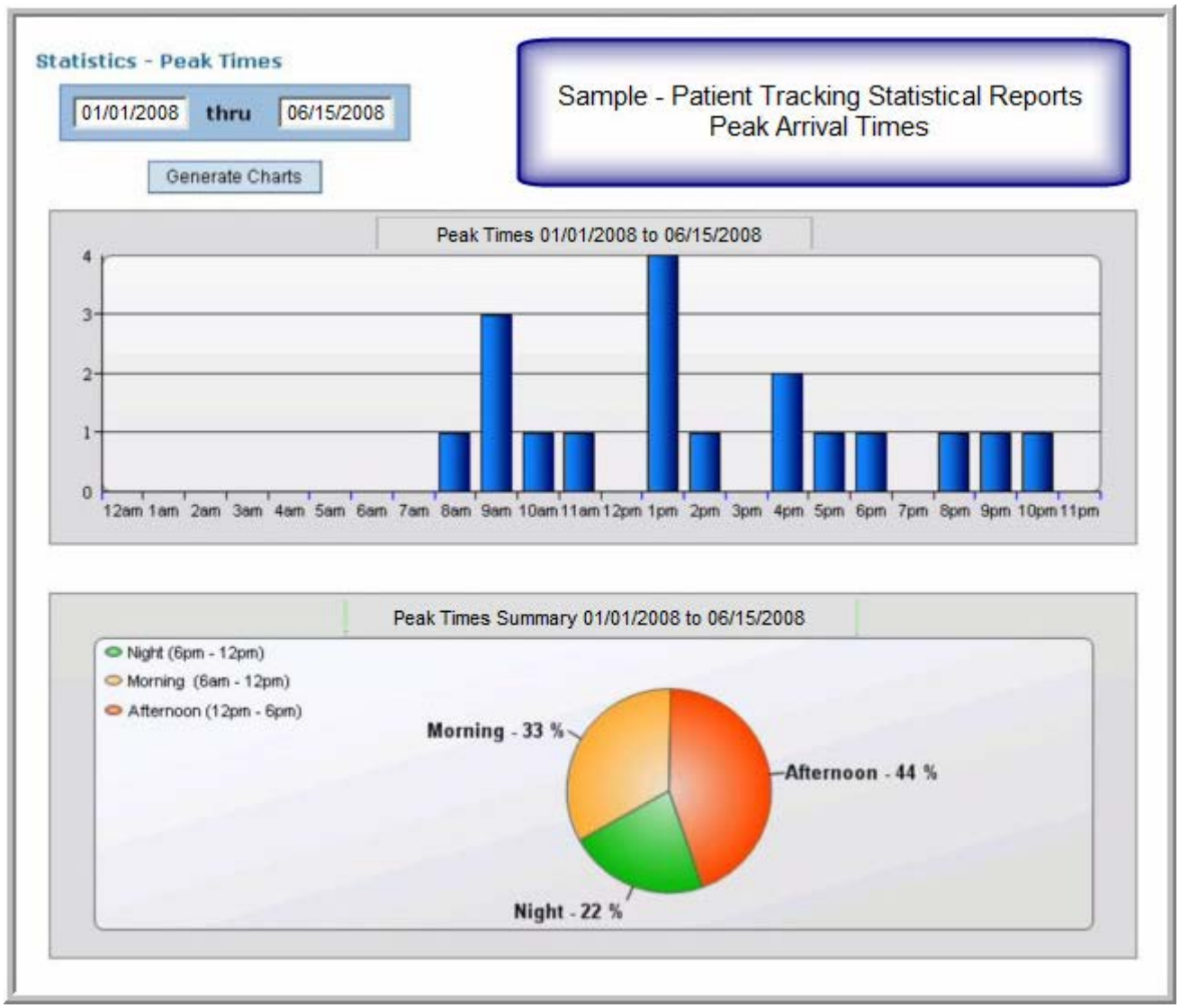
Health care professionals understand that determining room availability, knowing if a patient has recently been treated, and monitoring a patient's total time in care are important but difficult tasks in a busy healthcare organization.

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 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% 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.

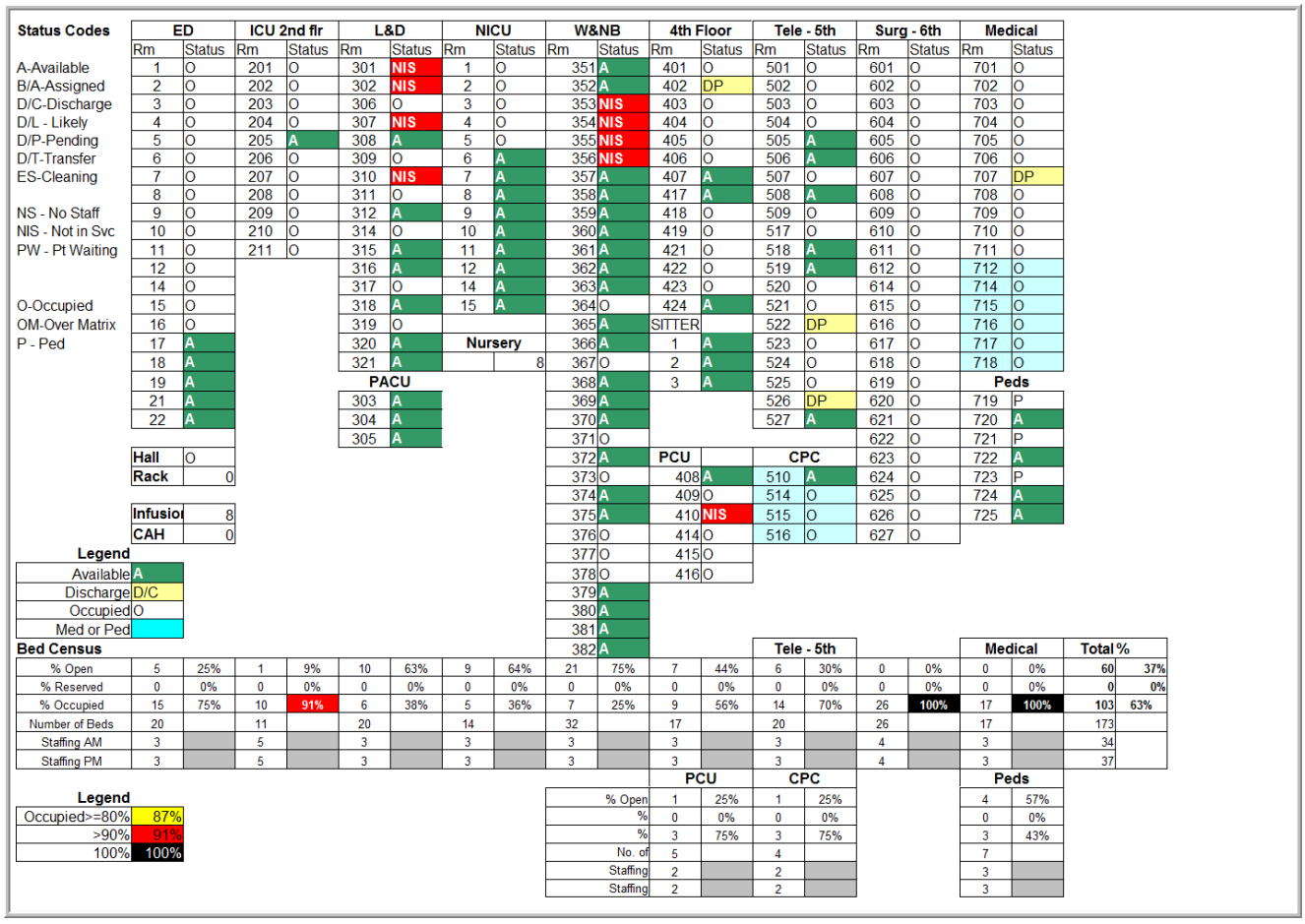
There are various tools to assist in the process of tracking patient flow and equipment. Some facilities utilize RFID (Radio Frequency Identification) technology to support these processes. RFID is a system that transmits the identity of any object or person (in the form of a unique serial number) wirelessly 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.



CENSUS MANAGEMENT

Strategic management of hospital beds has become a high-pressure requirement in today's world of health care facilities needing to do more with fewer resources. Hospitals operate more efficiently by determining the right level of care, bed availability, and occupancy rates. Manually generating a paper nightly census will not meet the needs of most hospitals. Using an electronic bed management system will provide timely notification of hospital activity, eliminate delays, and enable management to recognize and manage hospital stays on a current basis. Additionally, information from the electronic system may interface with other clinical or housekeeping systems to facilitate communication among the various departments.

Example of an electronic census management system:



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	
% Open	5	25%	1	9%	10	63%	9	64%	21	75%	7	44%	6	30%	0	0%	0	0%
% Reserved	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%
Number of Beds	20		11		20		14		32		17		20		26		17	
Staffing AM	3		5		3		3		3		3		3		4		3	
Staffing PM	3		5		3		3		3		3		3		4		3	

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	

CUSTOMER INFORMATION

Maintaining patient confidentiality is one of the most important duties of any health care organization; however there are instances when limited information may be relayed to others without the patient's express permission.

Opting Out of the Facility Directory

Patients have the right to restrict access to their Protected Healthcare Information (PHI) when being treated in a healthcare facility by "Opting Out" of the facility directory. A facility directory is defined as the storage repository that contains the patients name and location within the facility. This repository may be electronic or paper based. By selecting the option to "opt out" of the facility directory, a confidentiality flag is placed in the computer system, patient tracking system, and/or on the patients chart alerting staff that no information may be disclosed to callers, visitors, florists, or clergy.

Patient access employees are required to ask if the patient wishes to "opt out" of the facility directory and should educate the patient on the implication of their choice. Certain patient populations such as correctional and psychiatric patients are usually

deemed automatically confidential and facilities restrict the release of information related to these patients except information required by law.

Medical Record Release

The patient record is a tool for documenting the care of the patient, whether the format is paper-based or computer-based. The purpose of the medical record is to:

- provide a means of communication between the physician and other members of the healthcare team providing care to the patient
- provide a basis for evaluating the adequacy and appropriateness of care
- provide data to substantiate insurance claims
- protect the legal interest of the patient, the facility and the physician
- provide clinical data for research and education

The provider owns the physical health records but the patient has the right to inspect, obtain a copy of, and restrict release of the medical record. Specific rules apply to the release of Protected Health Information both formally and informally.

Protected Healthcare Information (PHI) is any information that may be used to identify the patient. Protection of PHI is one of the primary aims of HIPAA. There should be evidence that the requestor has a legitimate right to the information on a “need-to-know” basis. The patient has a right to know who has accessed his PHI. Except for limited circumstances, the patient should provide written consent for the release of any PHI.

Healthcare organizations are required to have policies and procedures in place to protect PHI both electronically and physically. Physical safeguards include policies on unique user identification numbers and passwords to access electronic systems, policies on the appropriate disposal of printed PHI, and recommendations on equipment that may be to ensure compliance, and education on appropriate staff behavior that is conducive to protecting patient privacy and confidentiality.

DEPARTURE OR DISCHARGE

The Importance of Collecting Patient Liability

The rising cost of healthcare is leading more insurers and employers to shift a greater share of their healthcare costs to consumers. Revenues directly from patients are becoming increasingly important to a hospital’s bottom line. Collecting from a patient is significantly different than making an insurance claim. Best practices should begin with the patient’s first encounter with the healthcare system – at the time of scheduling or registration – in order to:

- Assess the patient’s insurance coverage and other financial resources
- Screen all patients to determine ability to pay vs. those requiring assistance
- Present the patient with an estimated bill itemizing his/her financial obligations
- Secure payment from those who can pay at point-of-service (POS) and arrange for payment terms for balance owed based on the hospital’s collection policies

- Find payment sources for those who cannot afford care (identify potential federal, state, local, private and charity funding sources) and automate the application process

Following these best practices boosts hospital efficiency, reduces costs, improves patient satisfaction levels, as well as addresses regulatory requirements for pricing transparency and patient advocacy.

Hospitals today face growing financial challenges due to a major shift in the way they are compensated. Traditionally, healthcare providers obtained most of their revenue from insurers and government health programs; however, as healthcare costs escalated 5.5 times the rate of general inflation between 1999 and 2004, insurance companies, employers, and federal government programs shifted more of the costs to consumers in the form of higher co-pays and deductibles.

The percentage of employers offering health coverage fell nine percent between 2000 and 2005 while the number of Americans without health insurance coverage rose to 46.6 million people. As a result, self-pay has become the fastest growing hospital revenue segment, jumping from 5% on average in 2000 to more than 10% in 2004. With the growing prevalence of high-deductible, consumer-directed health plans, self-pay could easily exceed 30% of hospital revenues by 2012.

With the growth in self-pay and uninsured populations has come an increase in bad debt. Most hospitals collect between 2% and 8% of charges to uninsured patients. With overall margins averaging only 3% to 5%, hospitals cannot afford to ignore self pay accounts. A January 2006 survey in Modern Healthcare found that 67% of hospital chief executives listed financial challenges as one of their top 3 concerns, with 68% specifically identifying bad debt as one of their biggest issues.

Federal and state governments are also providing relief to patients who cannot afford to pay, as well as placing hospitals under greater scrutiny regarding their tax exempt status. Numerous states have adopted legislation related to these topics. One example comes from the Illinois House Healthcare Availability and Access Committee passing two related bills:

(1) The Tax Exempt Hospital Responsibility Act ensures that hospitals with beneficial tax-exemptions invest at least 8% of total operating costs in providing care for poor patients.

(2) The Hospital Fair Billing and Collection Practices Act requires all tax-exempt and for-profit Illinois hospitals to avoid unfairly aggressive and harassing tactics when seeking payment from patients.

The private sector is also placing new pressures on hospitals, as well as being a key driver in the expansion of healthcare consumerism. ‘Healthcare Spending Accounts’ with high deductibles (e.g., $5,000 to $10,000 or more) require hospitals to seek more

reimbursement directly from patients that would previously have been collected from insurance companies. For hospitals that do not have effective patient payment collection practices in place, ever greater portions of the hospital's bottom line are at risk.

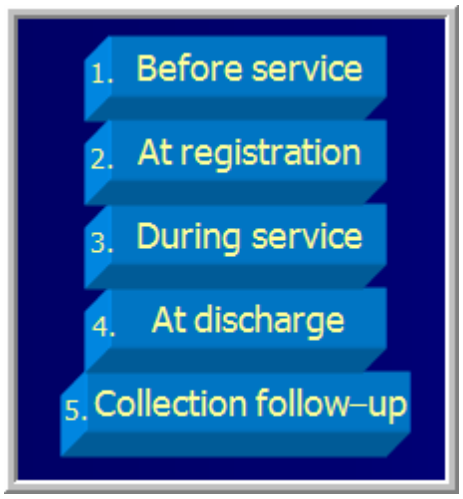
Historically, most hospitals' up-front collection efforts have focused only on patient's copay and perhaps his or her deductible. Today's financial challenges see more hospitals attempting to take the next step and determine estimated charges for services at time of registration. Others are working to present the contractual allowable charges based on the payors' contract with the hospital. However, the ultimate approach is to take into account the patient's benefits plan and the current year-to-date accumulation status for deductibles, co-pays, and out-of-pocket maximums.

Calculating Estimated Patient Liability

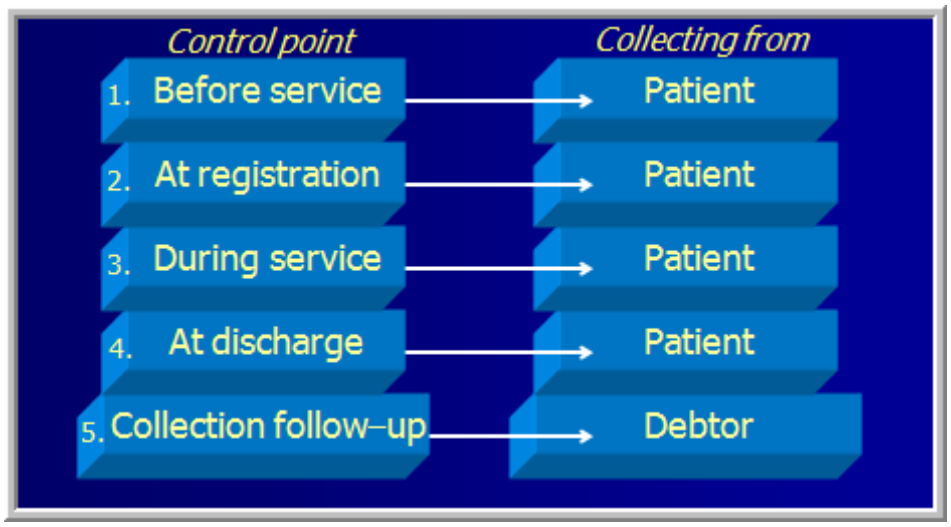
From the first day a healthcare provider has contact with a patient until the time the patient's bill is settled, the account moves through a predictable series of steps known as the Revenue Cycle. Different members of patient access and Patient Business Services perform actions that affect the entire account flow.

Many healthcare providers unintentionally make the mistake of assuming the collection process begins with collection follow–up. However, as the diagram below shows, there are four additional major control points for collections before follow–up begins. The activities and communication that occurs during these four control points will affect whether or not a patient's bill will be collected.

The Five Major Control Points for collections:



There is a psychological advantage of collecting during the early stages of the revenue cycle. Consider who is being asked to pay during those stages. When collecting during the first four control points, the interaction is with a patient – not a debtor. Experience has shown patients to be more likely to pay their liability than a debtor.



In order to accurately calculate the estimated patient liability, the following information is necessary:

- Insurance reimbursement method based on the contract with the facility
- Percentage contract
- Per diem
- DRG
- Fixed Rate or Case Rate
- Capitation
- Estimated total charges, if necessary based on the reimbursement method
- Patient's insurance benefits (policy provisions)
- Remaining amount due for deductible
- Co-insurance percentage
- Co-payment amount
- Remaining amount due for the maximum out-of-pocket (OOP), including or excluding the deductible

It is important to understand the following definitions to accurately calculate patient liability.

Deductible: A portion of the covered expenses (typically $100, $250 or $500) that an insured must pay per benefit period before benefits are paid by the insurance plan. Deductibles are standard in many indemnity and PPO policies, and are usually based on a calendar year. Since the deductible must be paid before the insurance pays any benefits, that amount must be removed from the calculation at the beginning.

Maximum Out-of-Pocket: The most money an insured can be expected to pay for covered expenses per benefit period. The maximum limit varies from plan to plan. Some insurance companies count deductibles, co-insurance, or co-payments toward the limit, others do not. Once the maximum out-of-pocket has been met, many health plans pay 100% of certain covered expenses.

Patient out of pocket expenses continue to rise and the obligation to collect from the patient at the time or service is important to the facilities cash position. At the point of registration, accurate information regarding the patients out of pocket obligations must be calculated and communicated to the patient.

Steps to Calculate Patient Liability – Managed Care

CALCULATING INSURANCE PAYMENT AND PATIENT LIABILITY

MANAGED CARE

Step	Process Description	Formula	
1	Estimated TOTAL CHARGES based on resources provided by facility. Total charges are needed *IF* the insurance contract reimburses based on charges		(A)
2	Determine CONTRACTUAL DISCOUNT for type of service provided	(Per Contract)	(B)
	- Percent of charges		
	- Per diem		
	- DRG		
	- Fixed Rate or Case Rate		
3	Calculate TOTAL CONTRACT PAYMENT AMOUNT by subtracting contractual discount from total charges *or* enter the CONTRACT PAYMENT AMOUNT for the DRG, Per diem, Fixed Rate, etc.	(A-B) or (B) for fixed payment amount	(C)
4	Determine unmet DEDUCTIBLE amount based on insurance verification		(D)
5	Calculate TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(C-D)	(E)
6	Determine patient COINSURANCE RATE based on insurance verification		(F)
7	Calculate patient's COINSURANCE AMOUNT	(E x F)	(G)
8	Calculate TOTAL PATIENT LIABILITY *cannot exceed remaining OOP maximum*	(D + G)	(H)
9	Calculate TOTAL INSURANCE PAYMENT	(E x (100-F))	(I)
10	VERIFY ACCURACY	(H + I)	= C

Note - the TOTAL PATIENT LIABILITY cannot exceed the patient's maximum out of pocket amount

EXAMPLE # 1:

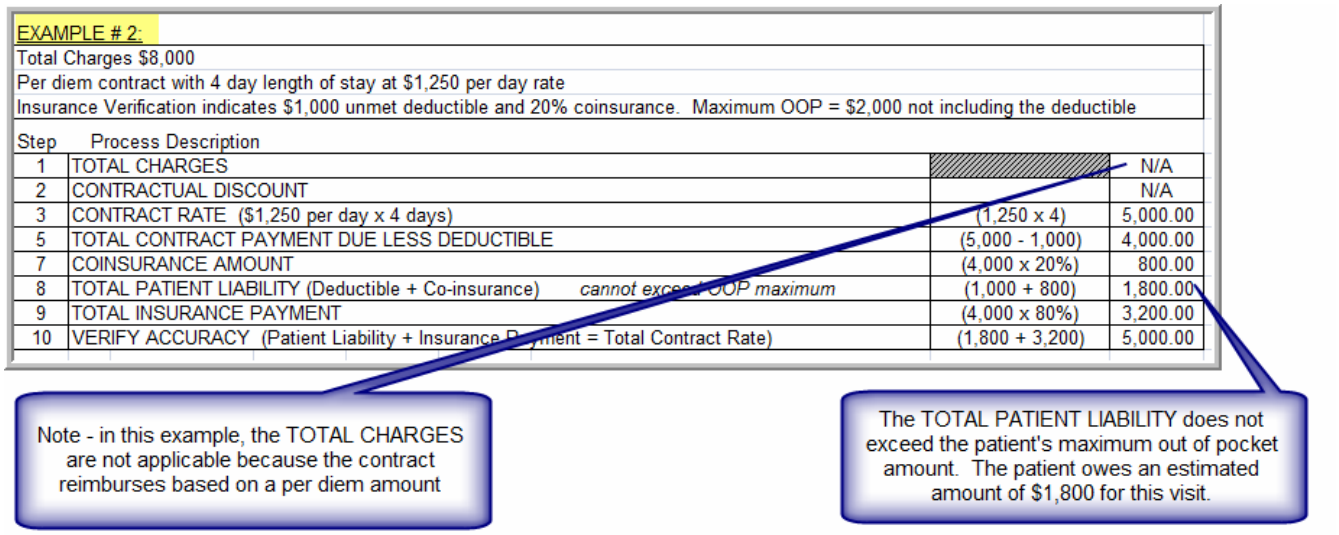
Total Charges $400

The patient's insurance has a contract with your facility that reimburses based on a percentage off of the total charges. The contract allows for a 25% contractual discount.

Insurance Verification indicates $100 unmet deductible and 10% coinsurance. Maximum OOP = $1,500 not including the deductible

Step	Process Description		
1	TOTAL CHARGES		400.00
2	CONTRACTUAL DISCOUNT	(400 x 25%)	100.00
3	CONTRACT RATE	(400 - 100)	300.00
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(300 - 100)	200.00
7	COINSURANCE AMOUNT	(200 x 10%)	20.00
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(100 + 20)	120.00
9	TOTAL INSURANCE PAYMENT	(200 x 90%)	180.00
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(120 + 180)	300.00

Note - the TOTAL PATIENT LIABILITY does not exceed the patient's maximum out of pocket amount. The patient owes an estimated amount of $120.00 for this visit.



EXAMPLE # 2:

Total Charges $8,000

Per diem contract with 4 day length of stay at $1,250 per day rate

Insurance Verification indicates $1,000 unmet deductible and 20% coinsurance. Maximum OOP = $2,000 not including the deductible

Step	Process Description		
1	TOTAL CHARGES		N/A
2	CONTRACTUAL DISCOUNT		N/A
3	CONTRACT RATE ($1,250 per day x 4 days)	(1,250 x 4)	5,000.00
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(5,000 - 1,000)	4,000.00
7	COINSURANCE AMOUNT	(4,000 x 20%)	800.00
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(1,000 + 800)	1,800.00
9	TOTAL INSURANCE PAYMENT	(4,000 x 80%)	3,200.00
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(1,800 + 3,200)	5,000.00

EXAMPLE # 3:

Total Charges $27,645

Insurance contract rate -- DRG rate for the procedure $8,293.50

Insurance Verification indicates $363 unmet deductible ($500 deductible -- $137 already met) and 20% coinsurance. Maximum OOP = $1,500 *including* the deductible

Step	Process Description		
1	TOTAL CHARGES		N/A
2	CONTRACTUAL DISCOUNT		N/A
3	CONTRACT RATE	Fixed Rate for the procedure	8,293.50
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(8,293.50 - 363)	7,930.50
7	COINSURANCE AMOUNT	(7,930.50 x 15%)	1,189.58
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(1,189.58 + 363.00)	1,552.58
9	TOTAL INSURANCE PAYMENT	(7,930.50 x 85%)	6,740.92
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(1,152.58 + 6740.92)	7,930.50

In addition to calculating the estimated amount due for the current or upcoming visit, patient access employees should also review previous balances to determine if the patient has any liability. If the patient / guarantor owes for a previous account or accounts, the balance(s) should be requested during the process of collecting the current estimate.

Many facilities provide a 'Patient Liability Letter' to the patient / guarantor to communicate the amount due. That letter may provide information regarding the calculation for this visit and the balance due for previous visits.

If the patient only owes a co-payment amount as indicated on their insurance card, it is not necessary to utilize a tool to determine the amount due. For example, many insurance companies have a specified co-payment amount for an Emergency Room visit. After the patient has met EMTALA guidelines, patient access can request the amount listed on the insurance card without having to calculate the estimated amount due using a worksheet or tool similar to the one listed above.

Calculating Patient Liability – Medicare

The Medicare Part A deductible is due at the start of each new "spell of illness." A new spell of illness is defined as being out of an acute care or LTAC (Long Term Acute Care) hospital for more than 60 consecutive days. A daily coinsurance amount is due from the patient for days 61 – 90 of an inpatient spell of illness. A daily coinsurance amount is due from the patient for Lifetime Reserve Days (LTR) 91 – 120. The patient must sign a LTR waiver to authorize utilization of their LTR days.

The Medicare Part B deductible is due at the beginning of each calendar year. Patients usually meet this deductible with a doctor's office visit. The patient may also owe a 20% co-pay for most outpatient procedures.

Medicare Deductibles and Co-pay Table:

	Medicare Part A - Inpatient				Part B - Outpatient	
Year	IP Deductible 1-60	Coinsurance Days 61-90	Lifetime Reserve Days 91-120	SNF Co-pay 21- 100	OP Deductible	Co-pay
2008	$1,024.00	$ 256.00	$512.00	$ 128.00	$ 135.00	20% Fee Schedule
2007	$ 992.00	$ 248.00	$496.00	$ 124.00	$ 131.00	20% Fee Schedule
2006	$ 952.00	$ 238.00	$476.00	$ 119.00	$ 124.00	20% Fee Schedule
2005	$ 912.00	$ 228.00	$456.00	$ 114.00	$ 110.00	20% Fee Schedule
2004	$ 876.00	$ 219.00	$438.00	$ 109.50	$ 100.00	20% Fee Schedule
2003	$ 840.00	$ 210.00	$420.00	$ 105.00	$ 100.00	20% Fee Schedule
2002	$ 812.00	$ 203.00	$406.00	$ 101.50	$ 100.00	20% Fee Schedule

BILLING

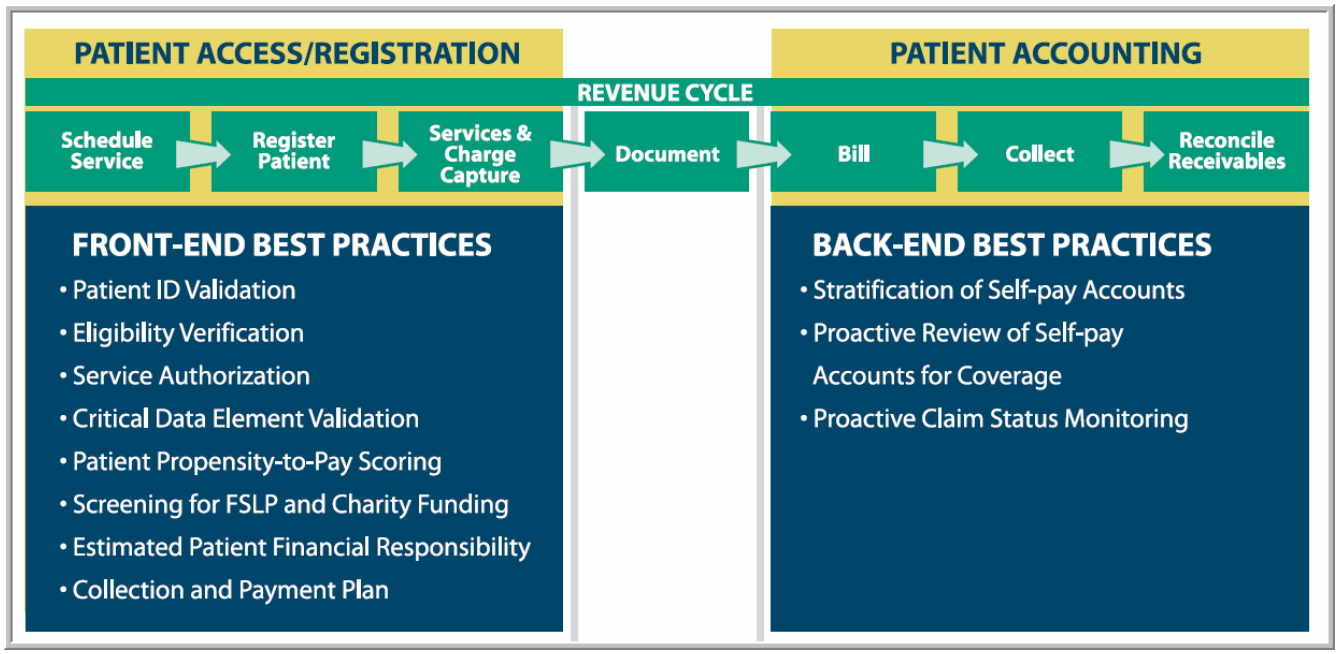
A persistent problem for hospitals is the high percentage of claims that payors reject resulting from inaccurate data entered during registration. For many hospitals, these inaccuracies remain the number one cause for claims being rejected or denied.

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 Critical Data Elements that are commonly entered in error include:

- Patient name on claim not matching patient name on file with payor
- Incorrect or missing Member ID
- Claim submitted to wrong payor (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 time of registration eliminates many downstream issues associated with billing payors and collecting from the patient resulting in improvements to patient satisfaction.



Future Development

DATA INTEGRITY

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 patients encounter or at the point of entry into the healthcare system. In order to understand how to measure and report data integrity, first, it is important to understand the types of data elements captured during the registration process and then review 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 subdivided into three sub categories: 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 The Joint Commission (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 Master Patient Index (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.

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:

- Legible
- 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

<u>Data Accuracy</u>

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 self correct
- Errors corrected earlier in the revenue cycle
- Clean data before the bill drops

Internal auditing provides a snap-shot of the results produced by current processes. Accuracy of the registration data results in fewer denials, rejected claims, and other delays. Data measured is used to implement performance improvement initiatives designed to meet the revenue cycle goals of reducing A/R and improving cash flows for the organization.

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 information technology (IT).

One of our most valuable resources is time. The largest expense item in the patient access budget is salary expense. Management of this valuable resource requires a collaborative effort between staff and management. 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

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 on-line 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
- on-line tools
- automation

CUSTOMER SATISFACTION

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 payors, and suppliers.

Customer Expectations

According to Press Ganey, “satisfied patients become loyal patients.” These patients will not only return but also refer family members and friends to the healthcare facility.

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 payor requirements, out-of-pocket expenses, financial assistance programs, and government regulations and guidelines and communicate this information to the patient.

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.

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, the staff member should ask the patient their preferred way to be addressed. Additional behavior 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 a 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.

Evaluating Customer Satisfaction

There are two methods of 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:

- Letters from patients and families
- Conversation with patients/families

Both positive and negative feedback have a purpose in health care 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.

Survey Results

Surveys are the best method to find out if a customer is satisfied. Customer 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 customer satisfaction survey soon after the healthcare encounter when the experience is still fresh in the patients mind.

Surveys are used within individual healthcare organization to measure satisfaction and engage in quality improvement initiatives. Health care consumers and health insurance companies also use customer satisfaction surveys. Health care consumers are demanding more information on where to seek services and are turning to published health care surveys to find organizations that meet or exceed expectations. Many health insurance companies have service excellence programs and are moving towards pay for performance reimbursement methodologies or allowing members to seek specific specialty services only at health care organizations that meet or exceed a level of performance benchmark.

Health care organizations recognize the need to participate with and publish survey results. Survey organizations such as JD Power and Press Ganey provide customer 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

When initiating a customer satisfaction survey it is important to determine:

- What data measurements are required
- What data measures are important to the organizations decisions making process
- What data measures are important to day to day management

In the case of a customer satisfaction survey, the data relates to the customer perspective of their health care encounter. 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 relate to the service provided by individual care givers showing compassion, concern, and empathy more than clinical competence. Health care consumers are as interested in service and staff behaviors during their health care encounter as they are in clinical outcomes.

In addition to customer satisfaction surveys, health care 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.

Quality Improvement

Customer 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 who in turn evaluate the information and initiate a course of action to remedy identified problems.

Accrediting bodies such as TJC and 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 health care services to meet the needs of individuals and others.

TJC defines performance improvement as: the continuous study and adaptation of a health care organizations functions and processes to increase the probability of achieving desired outcomes.

In addition to the requirements placed on health care organizations to participate in specific clinical quality improvement initiatives, health care organizations continuously apply quality improvement principles to processes in all aspects of the facility, including patient access services.

STAFF EDUCATION AND COMPETENCY

Performance Indicators

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

There are a number of KPI for the healthcare revenue cycle. The revenue cycle correlates strongly with the patient-flow process, which runs from scheduling and registration through treatment, discharge, and collection. In the NAHAM model, patient flow encompasses Pre-Encounter, Encounter and the Continuum of care. In the past, hospitals tended to focus their efforts at the end of this process, on billing and collection. However, most revenue-cycle problems originate early on, at the time when the hospital is collecting and verifying patient information needed to ensure submission of a clean claim and receipt of full payment. Rather than address problems retrospectively, hospitals have shifted their focus on patient access processes that help ensure the problems do not arise in the first place.

Avoiding problems or addressing them in a timely manner requires effective alignment of revenue-cycle components. Lack of alignment between clinical and financial functions is a leading cause of revenue-cycle problems for many hospitals. Proper organizational alignment and focus of patient access, clinical, and patient financial services (PFS) functions will positively affect revenue-cycle results as monitored by the Key Performance Indicators.

The following Key Performance Indicators 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

The following Key Performance Indicators are generally monitored for various departments in the revenue cycle:

- Days in receivables/Accounts receivable (A/R) days
- Total cash collections
- Discharged not final billed (DNFB)
- Rejected claims/Clean claim percentage
- Denial percentage
- Credit balances
- Cost to collect ratio
- Charity expense
- Bad debt expense

<u>Performance Improvement Methods</u>

Process improvement is the act of incrementally exceeding the expectations or requirements of a process through continual enhancements and refinements. Process improvement is an ongoing responsibility that must continually adapt to changing business requirements and technologies. In order to achieve positive results (as monitored by Key Performance Indicators) various methods are utilized to improve performance.

To effectively conduct process improvement, objectives and outcomes must be measurable and well understood. The idea of improving processes has taken on many forms, such as: FOCUS-PDCA, Total Quality Management (or TQM), Process Reengineering, Quality Function Deployment (QFD), and Six Sigma.

There are various methods, techniques and tools utilized to improve performance. One or more of these methods may be utilized in patient access.

FOCUS - PDCA is a systematic method for improving processes. Through FOCUS - PDCA, knowledge of how a process currently performs is used to test process changes. The purpose of these process changes is to improve the product or service from the customer's viewpoint. FOCUS - PDCA is an extension of the PDCA cycle sometimes called the Deming or Shewhart cycle. Simply, PDCA is the scientific method used to achieve improvement.

F – Find a process improvement opportunity
O – Organize a team who understands the process
C – Clarify the current knowledge of the process
U – Uncover the root cause of the variation or poor outcome
S – Start the “Plan-Do-Check-Act” cycle

P – Plan
D – Do
C – Check
A – Act

Did you know? The PDCA cycle is also known by two other names, the Shewhart cycle and the Deming cycle.

Walter A. Shewhart first discussed the concept of PDCA in his 1939 book, Statistical Method from the Viewpoint of Quality Control. Shewhart said the cycle draws its structure from the notion that constant evaluation of management practices, as well as the willingness to adopt process changes and disregard unsupported ideas, are keys to the evolution of a successful enterprise.

Deming is credited with encouraging the Japanese in the 1950s to adopt PDCA. The Japanese eagerly embraced PDCA and other quality concepts, and to honor Deming for his instruction, they refer to the PDCA cycle as the Deming cycle.

Six Sigma is a process improvement technique for blending organizational wisdom with proven statistical tools to improve both the efficiency and effectiveness of a process. The ultimate goal is to create economic wealth for the customer and the provider alike.

Six Sigma is a highly disciplined method for improving processes. The central idea behind Six Sigma is that if you can measure how many "defects" you have in a process, you can systematically figure out how to eliminate them and get as close to "zero defects" as possible. To achieve Six Sigma, a process must not produce more than 3.4

defects per million opportunities. A Six Sigma defect is defined as anything outside of customer specifications.

("Six Sigma" is a federally registered trademark of Motorola.)

Leading organizations base Six Sigma around a few key concepts:

- *Critical to Quality*: Attributes most important to the customer/patient
- *Defect:* Failing to deliver what the customer/patient wants
- *Process Capability*: What your process can deliver
- *Variation:* What the customer/patient sees and feels
- *Stable Operations*: Ensuring consistent, predictable processes to improve what the customer/patient sees and feels
- *Design for Six Sigma*: Designing to meet customer/patient needs and process capability

Lean and Six Sigma are complementary in nature and, if performed properly, can produce unprecedented results. While Lean focuses on eliminating non-value added steps and activities in a process, Six Sigma focuses on reducing variation from the remaining value-added steps. Lean makes sure we are working on the right activities, and Six Sigma makes sure we are doing the right things right the very first time we do them. The two methodologies interact and reinforce one another.

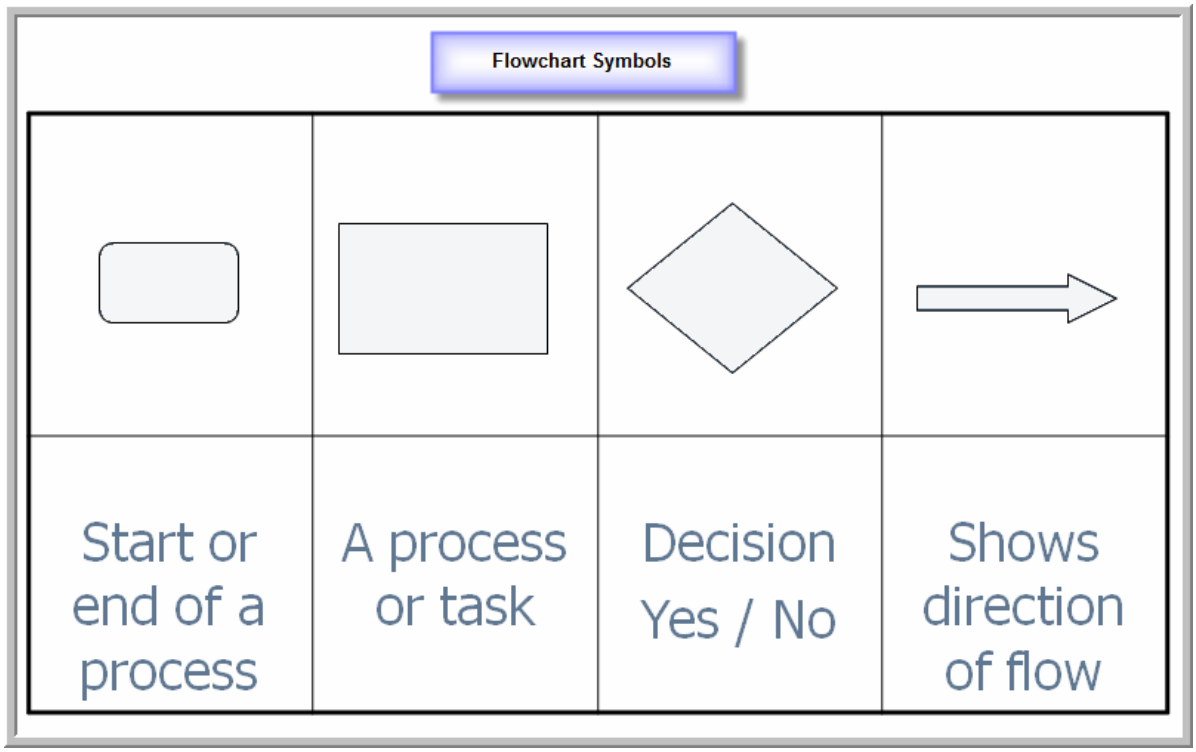
 **Did you know?** Approximately 30% to 50% of the cost in service organizations is caused by costs related to slow speed or performing rework to satisfy customer needs.

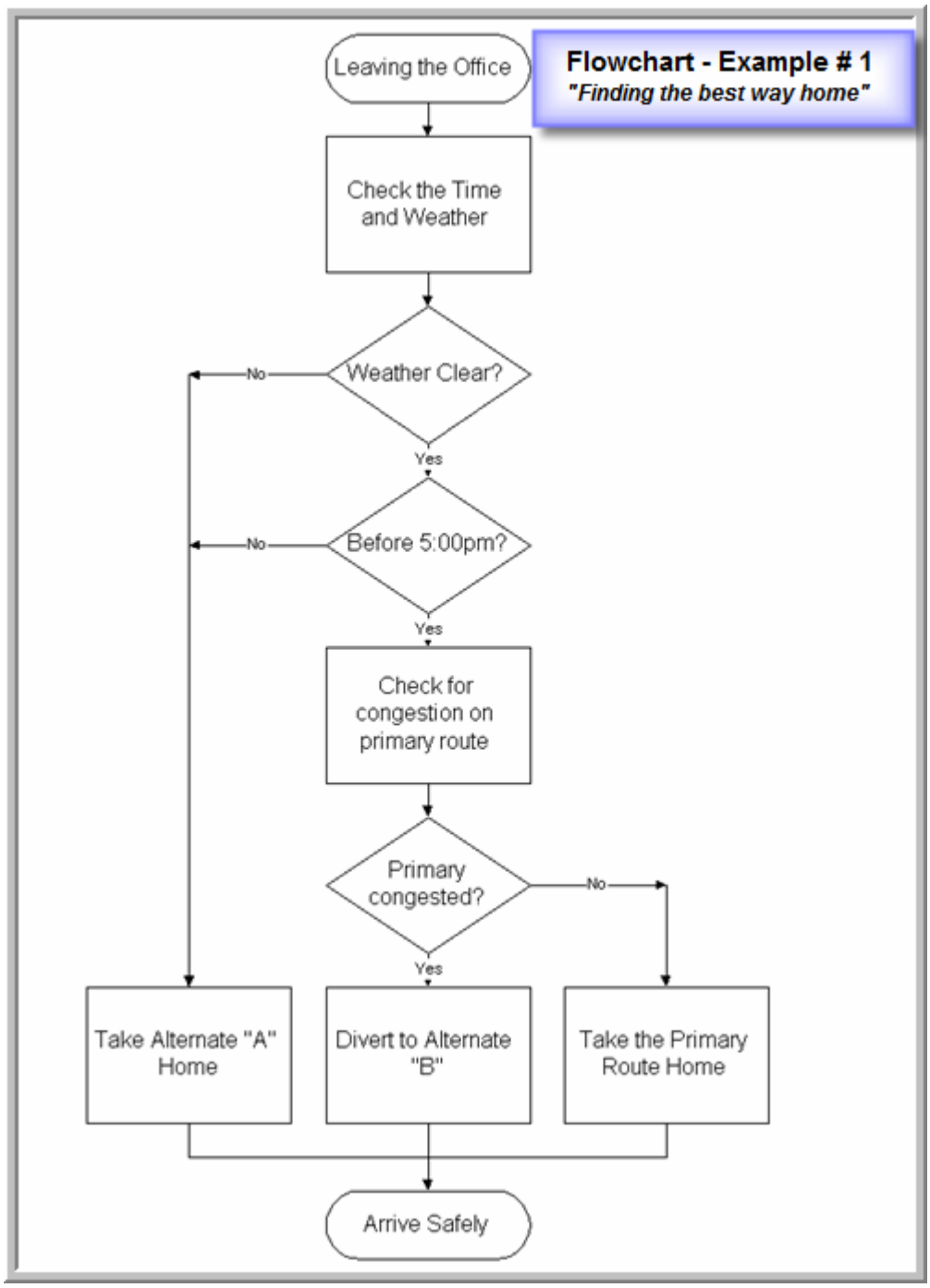
Process Reengineering is a process improvement technique that involves the fundamental rethinking and radical redesign of business processes to achieve dramatic improvements in cost, quality, service, and speed. It was popularized by Michael Hammer and James Champy in the early 1990s with the book Reengineering the Corporation. Words used to define Process Reengineering include:

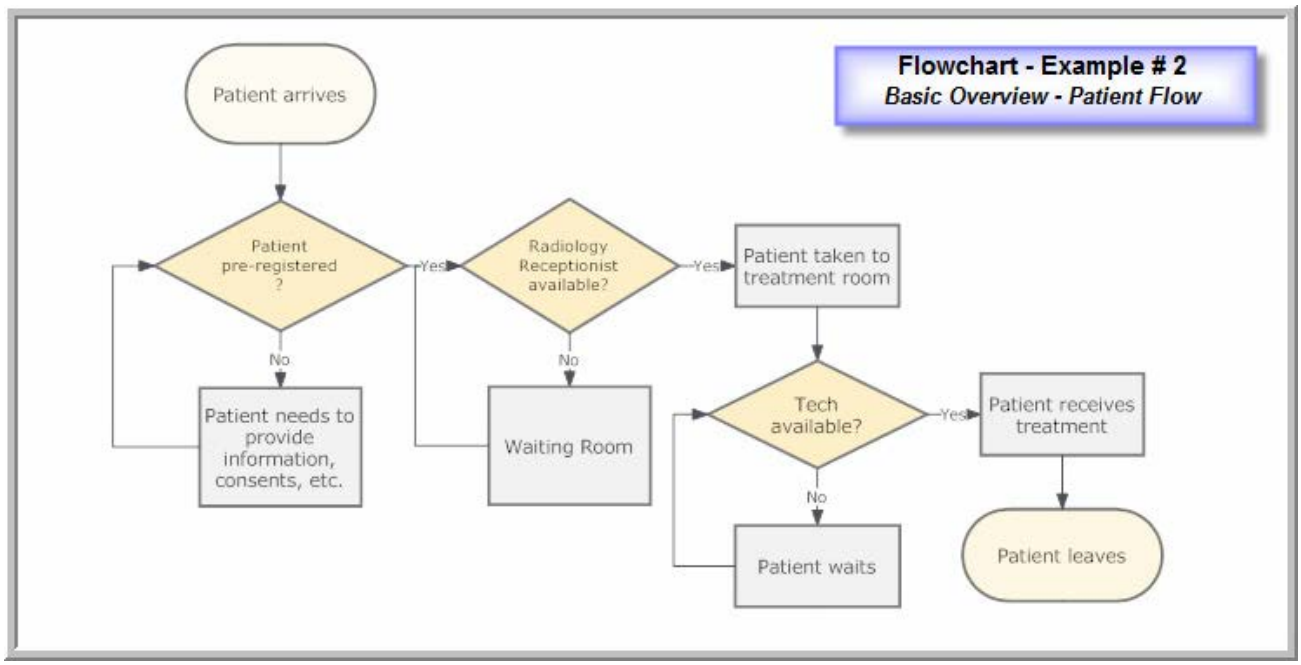
- *Radical* – extreme, not conservative or moderate. In terms of change, looking to create disruptive, undiscovered, challenging new systems.
- *Dramatic* – major, not incremental. In terms of improvements, looking to achieve 80-90%, not 10-20%; or 6-8 times, not 1-2 times.
- *Contemporary* – modern, not traditional or time-tested. In terms of measurement, throwing out previous ways and using new ones of reporting and managing.

<u>Performance Improvement Tools</u>
There are various tools utilized in process improvement methods:

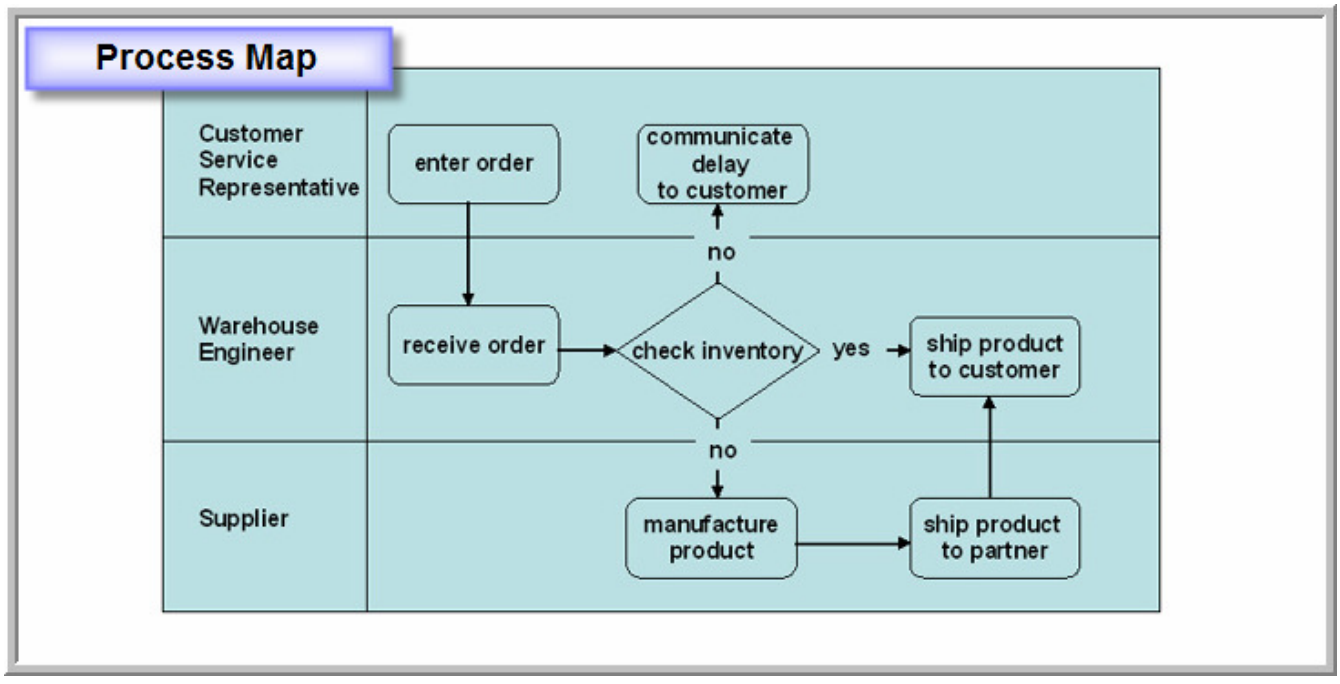
A flowchart is a graphical representation of activities that make up a process. Flowcharting a process down to the task level is the basis for analyzing and improving the process. There are several different types of flowcharts. Two types of flowcharts that are generally used in healthcare: block diagrams and functional flowcharts. Block diagrams are the simplest and provide a quick overview and functional flowcharts show the process flow between organizations and groups







A process map is a graphical picture of the actual workflow through a company. The format of a process map helps clarify who is responsible for a step or task in the process. Process maps are typically given names that relate to all the work that gets done between their beginning and end states. A process map creates a vocabulary for discussing an organization's business processes. Many patient access departments have process maps of their processes.



STAFF EDUCATION AND COMPETENCY

Patient Access Training Models

There are various methods for training patient access staff, including:

- "Hands-on" computer training
- Formal classroom training
- Peer-to-peer training
- CBT (computer based training)
- Self-paced training
- Role-playing
- Experiential

Different methods are utilized depending on the complexity of the topic and/or system.

Patient Access Training Modules

Patient access staff requires specialized training to learn the various systems and processes. The following topics may be included in the training for patient access associates:

- Computer systems training
- Insurance verification
- Pre-certification
- Calculating patient liability
- Overview of healthcare finance
- Medicare/Medicaid
- Service standards
- Managed Care
- Revenue cycle operations
- Medical terminology
- Scheduling
- Regulations: HIPAA, EMTALA, etc.
- Customer

Because of the complexities, most of the training should be conducted in a classroom with "hands-on" systems access and role-playing.

After the training, competence should be demonstrated through written and practical exams. Quality reviews will assist in identifying additional training needs or areas of focus.

Competence

Competence is a standardized requirement for an employee to properly perform a specific job. It encompasses a combination of knowledge, skills and behaviors utilized to improve performance. Competence is the state or quality of being adequately qualified to perform a specific role.

Behavioral competencies are distinct from technical competencies. Technical competencies – registering, verifying, calculating deposits - are typically learned in an educational environment or on the job. Behavioral competencies—adaptability, decisiveness, integrity, dealing with pressure--are learned through life experiences and form our behavior patterns.

Behavioral competencies

Behavioral competencies encompass knowledge, skills, attitudes, and actions that distinguish excellent performers; identify behaviors that enable employees to achieve superior performance; and provide a “road map” to understanding how to achieve success as a patient access associate.

The following behavioral competencies are commonly considered applicable to the role of a patient access associate:

- Ability to maintain composure
- Able to stay calm and professional and maintain a positive manner during difficult or stressful situations.
- Adaptability
- The ability and willingness to change work practices, priorities or procedures in response to changing conditions, multiple work demands, or after encountering difficulties.
- Building collaborative relationships
- The ability to develop, maintain, and strengthen partnerships with others inside or outside the organization who can provide information, assistance, and support
- Initiative
- Identifying what needs to be done and doing it before being asked or before the situation needs it.
- Listening
- Pays attention to and understands when others are talking. Gives the other person non-verbal and verbal signals that he/she is listening.
- Multi-tasking
- Uses time wisely; is able to accomplish several tasks at the same time. Able to prioritize tasks to use their time efficiently.
- Verbal communication
- The ability to express oneself clearly in conversations and interactions with others.
- Working autonomously
- Able to work without close supervision. This includes making sure tasks are finished on time without error and up to quality standards.
- Goal orientation
- Setting and striving to accomplish work objectives, this includes showing a strong drive to follow through with and complete what one started.
- Professional integrity
- Responding to questions honestly, advising peers and supervisors in a truthful, straight forward manner.
- Thoroughness
- Ensuring that one's own and others' work and information are complete and accurate; following up with others to ensure that commitments have been satisfied.
- Troubleshooting

- Locates and eliminates sources of trouble to get to the cause of a problem and solve it.

Technical Competencies

Technical competencies include registering, verifying, and calculating deposits. They are typically learned in an educational environment or on the job. The following technical competencies are generally required in patient access:

- Verbal Communication
- Written communication
- Mathematical skills
- Computer proficiency
- Medical terminology
- Insurance terminology/requirements
- Knowledge of the Revenue Cycle
- Basic CPT / ICD coding
- Facility codes (e.g., disaster codes)
- Regulatory standards (e.g., EMTALA, HIPAA, etc.)
- Clinical pre-requisites (e.g., procedure preps)
- Customer Service scripting /key phrases

Additional technical skills may be required based on the requirements for the position including:

- Microsoft Excel, Word, PowerPoint and/or Access Database
- Financial Analysis
- Third Party Eligibility requirements
- Charity processing
- Bad debt reserve policy
- Bilingual

COMPETENCY CHECKLIST

Purpose: These are the standards of the technical competencies necessary for performance and/or clinical practice. They supplement continuing education programs and the quality improvement program.

To meet competency standard the employee must demonstrate proficiency in performing the technical procedures safely as evidenced by department specific criteria.

Standards Met By:

A. Demonstration
B. Direct Observation/Checklist
C. Video Review
D. Skills Lab
E. Self Study/Test
F. Data Management
G. Other

NAME: **JOB TITLE:**

CORE COMPETENCIES	DATE	STANDARD MET BY	SUPERVISORS INITIALS	STANDARD MET	STANDARD NOT MET	COMMENTS
• Provides knowledge of mission statement.						
• Performs proper customer service techniques (ie: phone etiquette).						
• Visibly wears I.D. Badge at all times.						
• Demonstrates ability to communicate with others (oral and written).						
• Describes Total Quality Initiative program.						
• Works effectively in a team atmosphere.						
• Demonstrates ability to make logical decisions and seek assistance if necessary.						
• Demonstrates knowledge of the Code of Ethics.						
• Insures all levels of Confidentiality are maintained.						
CORE SAFETY COMPETENCIES						
• Performs specific roles/responsibilities during emergencies.						
• Demonstrates knowledge of fire system, fire extinguishers and evacuation policy.						

Sample - Competency Checklist
Page 1

COMPETENCY	DATE	STANDARD MET BY	SUPERVISORS INITIALS	STANDARD MET	STANDARD NOT MET	COMMENTS
• Uses fire extinguisher properly.						
• Explain how to obtain alternate communication systems during emergencies.						
• Explains how to properly obtain supplies/equipment during emergencies.						
• Demonstrates ability to contact security in an emergency situation.						
• Demonstrates knowledge of accident report forms and uses them correctly.						
• Explains workers compensation guidelines correctly.						
• Indicates knowledge of OSHA standards of: • Hazardous Communications						
• LockOut/Tag Out						
JOB RELATED COMPETENCIES						

Sample - Competency Checklist
Page 2

BENCHMARKING

Healthcare organizations face many significant challenges today including financial pressures, increasing competition, human resource shortages, patient safety concerns, and growth in healthcare consumption. Overcoming these challenges requires innovative and robust solutions to achieve sustainable improvement and superior performance.

Benchmarking is an improvement tool whereby a company measures its performance or processes against other companies' best practices, determines how those companies achieved their performance levels, and uses the information to improve its own performance. Benchmarking is a continuous process whereby a company measures and compares all its functions, systems and practices against strong competitors, identifying quality gaps, and striving to achieve competitive advantage. Benchmarking is a method which should be used on a continual basis as best practices are always evolving.

Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).

The Balanced Scorecard is a strategic management system used to drive performance and accountability throughout the organization. The scorecard balances traditional performance measures with more forward-looking indicators in four key dimensions:

- Financial
- Integration/Operational Excellence
- Employees
- Customers

The Balanced Scorecard is an organizational framework for implementing and managing strategy at all levels of an enterprise by linking objectives, initiatives, and measures to an organization's strategy. The scorecard provides a view of an organization's overall performance. It integrates financial measures with other key performance indicators around customer perspectives, internal business processes, and organizational growth and innovation. A Balanced Scorecard for patient access may include:

- Upfront Cash Collections
- Admission/Registration Productivity
- Patient Satisfaction (overall facility and for patient access)
- Denial Rate
- Various categories of satisfaction are typically measured in healthcare:
- Physician
- Patient
- Employee

<u>Productivity</u>

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 and financial counseling interviews. 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%

Customer Satisfaction / Patient Loyalty

Every day, it becomes more obvious that excellent clinical outcomes alone do not increase the likelihood of a patient or their family to return or recommend a hospital's services to friends and family. Great care goes beyond a strict interpretation of clinical performance, and moves more to the complicated series of human connections between staff and patients. Simply put, improving the quality and frequency of human interactions improves healing.

The federal government has realized that listening to and acting on patients' feedback is critical to improving the quality of health care in America. Hospitals that have focused on patient-centered care will have a business advantage as transparency and public reporting garner more attention. Those who have not—with hospital performance laid out side-by-side for all to see—will be driven to improve. Likewise, payors—both the Centers for Medicare and Medicaid Services (CMS) and private insurers—are continuing to adopt quality metrics, including patient satisfaction, as measures of performance and value. As more payors move to a pay-for-performance model, organizations that do not provide high-quality care and service will receive smaller reimbursements. Hospitals across the nation are meeting these challenges by improving the patient experience. The national trend in patient satisfaction has continued its steady upward climb, demonstrating organizations' commitment to quality care. But this isn't enough. As health care consumerism becomes a reality, patients will expect—and even demand—the bar to be raised even higher. And in the face of transparency and heavy competition, it becomes a competitive necessity for individual hospitals to continually improve the quality of care they provide.

Studies show satisfied patients are more likely to adhere to medical advice and that emotional distress during a health care experience can actually hinder a patient's ability to heal. Various case studies, white papers, and webinars are readily available to provide in-depth research into the value of patient satisfaction in hospital, medical practice, and home health settings.

Patient Loyalty: Leaving patients with a positive feeling about the care they received is the primary goal; however an organization's viability rests on whether those feelings are translated into a tendency to use the facility for future healthcare needs—in other words, whether the organization is building loyal patients. Loyalty, more so than just satisfaction, is statistically linked to financial and growth metrics and overall sustainability.

Service recovery and staff recognition opportunities are maximized as a result of tracking patient, physician and employee satisfaction. Frequent management coaching sessions leverage best practices from both within and outside the organization to drive continuous improvement in quality and service delivery.

Physician referral patterns drive patient admissions and revenue, and significantly impact a hospital's reputation. An environment of reduced autonomy and increased time demands leave physicians feeling detached and uninvolved, placing hospitals at risk of physician defections. Since these physicians are in the trenches at your hospital every day, they have perspectives of your operation that need to be heard.

Peer review

Peer review is a process used for checking the work performed by one's equals (peers) to ensure it meets specific criteria. Peer review is used in working groups for many professional occupations because it is thought that peers can identify each other's errors quickly and easily, speeding up the time that it takes for mistakes to be identified and

corrected. In software development, peer review is sometimes used in code development where a team of coders will have a meeting and go through code line by line (even read it aloud possibly) to look for errors. The goal of all peer review processes is to verify whether the work satisfies the specifications for review, identify any deviations from the standards, and provide suggestions for improvements.

GLOSSARY OF QUALITY IMPROVEMENT TERMS

Accessibility - Ability of a patient or population to utilize needed healthcare services unrestricted by geographic, economic, social, cultural, organizational, or linguistic barriers.

Accreditation - A formal process by which a recognized body, usually a non-governmental institution, assesses and recognizes that a healthcare organization meets applicable, pre-determined standards.

Algorithm - Recommended patient management strategies designed to direct decision making, such as a structured flowchart, decision tree, or decision grid. Often algorithms are used in areas in which rapid decision making is required, e.g., emergency department.

Amenities - Features of health services that do not directly relate to clinical effectiveness but may enhance the client's satisfaction and willingness to return to the facility for further healthcare needs. These would include physical appearance and cleanliness of the health facility.

Bar chart - A graphic display of data in the form of a bar showing the number of units (e.g., frequency) in each category.

Baseline - An observation or value that represents the background level of a measurable quantity.

Benchmarking - A process of searching out and studying the best practices that produce superior performance. Benchmarks may be established within the same organization (internal benchmarking), outside of the organization with another organization that produces the same service or product (external benchmarking), or with reference to a similar function or process in another industry (functional benchmarking).

Best practice - A way or method of accomplishing a business function or process that is considered to be superior to all other known methods.

Brainstorming - A group process used to generate a large number of ideas about specific issues in a non-judgmental environment.

Case management - Coordination of services to help meet a patient's healthcare needs, usually when the patient has a condition which requires multiple services from multiple providers.

Cause-and-effect diagram - A display of the factors that are thought to affect a particular problem or system outcome. The tool is often used in a quality improvement program to group people's ideas about the causes of a particular problem in an orderly

way. (Also known as a fishbone diagram because of the shape that it takes when illustrating the primary and secondary causes.)

Certification - A process by which an authorized body, either a governmental or nongovernmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria.

Clinical pathway - A patient care management tool that organizes, sequences, and times the major interventions of nursing staff, physicians, and other departments for a particular case type (e.g., normal delivery), subset (e.g., hysterectomy), or condition (e.g., failure to breastfeed). (Synonyms: critical path, care map.)

Clinical practice guidelines - A set of systematically developed statements, usually based on scientific evidence, to assist practitioners and patient decision making about appropriate healthcare for specific clinical circumstances. (Synonyms: practice guidelines, guidelines, practice parameters.)

Coaching - Providing guidance, feedback, and direction to ensure successful performance.

Competence - Demonstrated performance and application of knowledge to perform a required skill or activity to a specific, predetermined standard.

Compliance - Performance according to standards

Continuity - A performance dimension addressing the degree to which the care for a patient is coordinated among practitioners and organizations and over time, without interruption, cessation, or unnecessary repetition of diagnosis or treatment.

Continuous Quality Improvement (CQI) - A management approach to improving and maintaining quality that emphasizes internally driven and relatively continuous assessments of potential causes of quality defects, followed by action aimed either at avoiding decrease in quality or else correcting it an early stage.

Control chart - A graphic display of the results of a process over time and against established control limits. The dispersion of data points on the chart is used to determine whether the process is performing within prescribed limits and whether variations taking place are random or systematic.

Effectiveness - The degree to which program or system objectives are being achieved.

Efficiency - The relationship of outputs (services produced) to inputs (resources used to produce the services). Increasing efficiency is a matter of achieving the same outputs with fewer resources or more outputs for the same amount of resources.

Evidence-based medicine - The practice of medicine or the use of healthcare interventions guided by or based on supportive scientific evidence. Also, the avoidance of those interventions shown by scientific evidence to be less efficacious or harmful.

Flowchart - A graphical representation of the sequence of activities, steps, and decision points that occur in a particular, discrete process, such as registering a client in a clinic.

Focus group - A client-oriented approach for collecting information wherein a group (10-12) of participants, unfamiliar with each other, meet to discuss and share ideas about a certain issue. Results of focus group discussions help to understand the beliefs and perceptions of the population represented by the group.

Gantt chart - A type of bar chart used in process or project planning and control to display planned work targets for completion of work in relation to time. Typically, a Gantt chart shows the week, month, or quarter that each activity will be completed and the person or persons responsible for carrying out each activity.

Health outcomes - The effect on health status from performance (or non-performance) of one or more processes or activities carried out by healthcare providers. Health outcomes include morbidity and mortality; physical, social, and mental functioning; nutritional status; and quality of life.

Histogram - A graphic display used to plot the frequency with which different values of a given variable occur. Histograms are used to examine existing patterns, identify the range of variables, and suggest a central tendency in variables.

Impact - A change in the status (e.g., health, standard of living) of individuals, families, or communities as a result of a program, project, or activity. For example, the impact of an immunization program might be the reduction in infant mortality by 15 percent.

Incentive - A tangible or intangible reward that is designed to motivate a person or group to behave in a certain way. For example, in an effort to reduce fertility, community health workers may be given a small amount of money for each woman they refer to the health clinic for family planning services.

Indicator - A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or the level of quality achieved.

Inputs - The resources needed to carry out a process or provide a service. Inputs required in healthcare are usually financial, physical structures such as buildings, supplies and equipment, personnel, and clients.

Job aid - A repository for information, processes, or perspectives that support work and activities by directing, guiding, and enlightening performance. Job aids are often printed or visual summaries of key points or steps essential to the performance of a task.

Just in time - A method of minimizing product and supply inventories by ordering materials as close as possible to the actual time of need. This reduces the cost of maintaining inventories of expensive items, such as newer biotechnology drugs. Precise timing and reliable suppliers are essential for this technique to work effectively.

Licensure - A process by which a governmental authority grants permission to an individual practitioner or healthcare organization to operate or to engage in an occupation or profession.

Measure -A number assigned to an object or an event. Measures can be expressed as counts (45 visits), rates (10 visits/day), proportions (45 primary healthcare visits/380 total visits = .118), percentage (12 percent of the visits made), or ratios (45 visits/4 health workers=11.25).

Outcomes - Results of a process, including outputs, effects, and impacts.

Output - The direct result of the interaction of inputs and processes in the system; the types and quantities of goods and services produced by an activity, project, or program.

Pareto chart - A graphic representation of the frequency with which certain events occur. It is a rank-order bar chart that displays the relative importance of variables in a data set and may be used to set priorities regarding opportunities for improvement.

Patient satisfaction - A measurement that obtains reports or ratings from patients about services received from an organization, hospital, physician, or healthcare provider.

Performance - The actual output and quality of work performed.

Problem solving - A quality improvement approach that involves objectively identifying the causes of a problem and proposing potential, often creative, solutions to the problem, which will be agreeable to multiple parties or individuals.

Problem statement - A concise description of a process in need of improvement, its boundaries, the general area of concern where quality improvement should begin, and why work on the improvement is a priority.

Procedure - Step-by-step instructions on how to perform a task based on technical and theoretical knowledge.

Process - A series of actions (or activities) that transforms inputs (or resources) into a desired product, service, or outcome.

Proportion - A special type of ratio expressing a relationship between the part and the whole. The numerator represents a portion of the total; the denominator is the total. For example, five male health workers out of a total of 15 health workers make a proportion.

Protocol - A detailed plan, or set of steps, to be followed in a study, an investigation, or an intervention, as in the management of a specific clinical condition (e.g., care of a patient with diarrhea).

Quality - The totality of features and other characteristics of a product or service that bear on its ability to satisfy stated or implied needs.

Quality assessment - Determination of how processes and services correspond to current standards, as well as a patient's satisfaction with the care received.

Quality assurance - That set of activities that are carried out to set standards and to monitor and improve performance so that the care provided will satisfy stated or implied needs.

Quality design - Systematic approach to service design that identifies the key features needed or desired by both external and internal clients, creates design options for the desired features, and then selects the combination of options that will maximize satisfaction within available resources.

Quality improvement - An approach to the study and improvement of the processes of providing healthcare services to meet needs of clients.

Quality indicator - An agreed-upon process or outcome measure that is used to determine the level of quality achieved. A measurable variable (or characteristic) that can be used to determine the degree of adherence to a standard or achievement of quality goals.

Quality management - An ongoing effort to provide services that meet or exceed customer expectations through a structured, systematic process for creating organizational participation in planning and implementing quality improvements.

Quality monitoring - The collection and analysis of data for selected indicators which enable managers to determine whether key standards are being achieved as planned and are having the expected effect on the target population.

Rate - A special form of proportion that includes specification of time. For example, the case-fatality rate of cerebral malaria is the number of cases of cerebral malaria who died over a period of time divided by the total number of cases of cerebral malaria in the same time period.

Ratio - The relationship between two numbers. For example, the ratio of males to females (known as the sex ratio) in a country is the number of males divided by the number of females. Any fraction, quotient, proportion, or percentage is a ratio.

Reliability - The extent to which the same result is achieved when a measure is repeatedly applied to the same group.

Root cause - The underlying reason for the occurrence of a problem.

Run chart - A visual display of data that enables monitoring of a process to determine whether there is a systematic change in that process over time.

Sample - A subset of the population. To the extent possible, a sample should possess all salient characteristics of the population from which it is drawn so that it is representative of the larger population.

Scatter diagram - A graphic display of data plotted along two dimensions. Scatter diagrams are used to rapidly screen for a relationship between two variables.

Specification - An explicit statement of the required characteristics for an input used in the healthcare system. The requirements are usually related to supplies, equipment, and physical structures used in the delivery of health services.

Standard - An explicit statement of expected quality. Standards represent performance specifications that, if attained, will lead to the highest possible quality in the system.

Standard operating procedure - Management processes that describe chronological steps to follow and decisions to make in carrying out a task or function.

Standing orders - Physician orders pre-established and approved for use by nurses and other professionals under specific conditions in the absence of a physician.

System - The arrangement of organizations, people, materials, and procedures associated with a particular function or outcome. A system is usually made of inputs, processes, and outcomes.

Team - A group of interacting individuals sharing a common goal and the responsibility for achieving it.

Technical performance -What the health provider actually does in a real situation.

Threshold - A level of achievement that determines the difference between what is deemed to be acceptable quality or not. For example, "the minimal acceptable level of coverage for the immunization program is 50 percent," means that every coverage figure less than that is an indication of a quality problem.

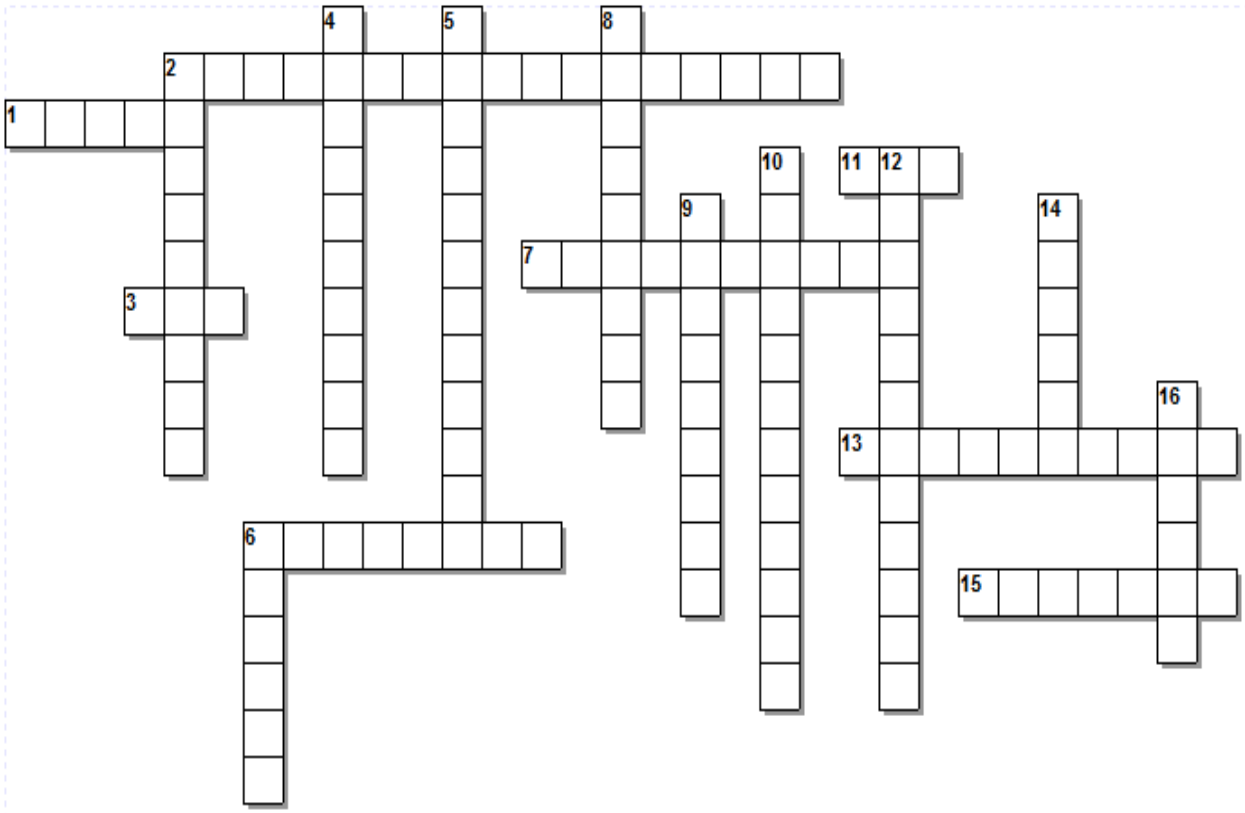
Total Quality Management (TQM) - An approach to quality assurance that emphasizes a thorough understanding by all members of a production unit of the needs and desires of the ultimate service recipients, a viewpoint of wishing to provide service to internal, intermediate service recipients in the chain of service, and a knowledge of how to use specific data-related techniques to assess and improve the quality of their own and the team’s outputs.

Validity - The degree to which an indicator accurately measures what it is intended to measure.

Variation - Differences in the output of a process resulting from the influences of people, equipment, materials, and/or methods.

Crossword Puzzle

A fun way to test your knowledge



Across

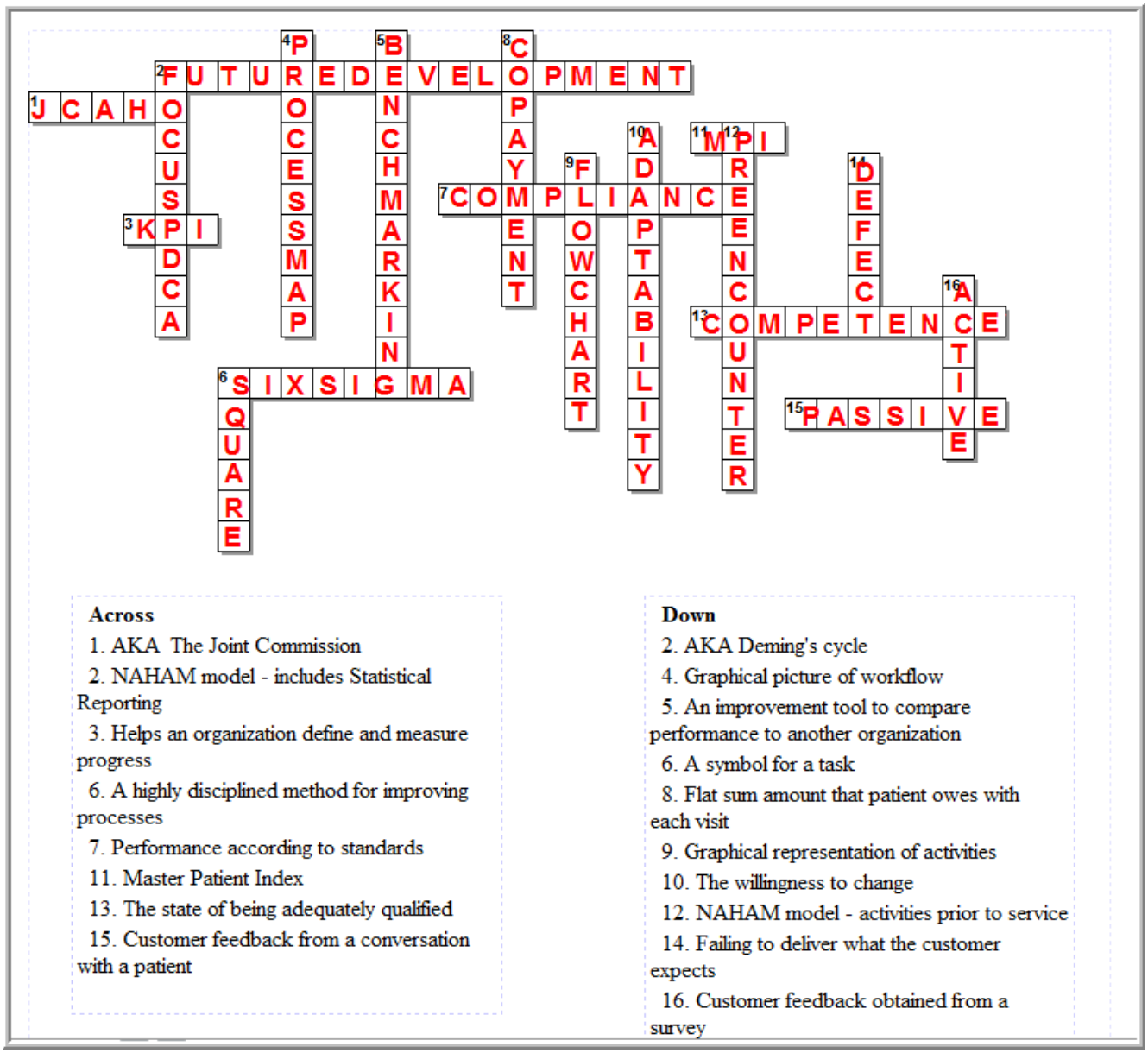
1. AKA The Joint Commission
2. NAHAM model - includes Statistical Reporting
3. Helps an organization define and measure progress
6. A highly disciplined method for improving processes
7. Performance according to standards
11. Master Patient Index
13. The state of being adequately qualified
15. Customer feedback from a conversation with a patient

Down

2. AKA Deming's cycle
4. Graphical picture of workflow
5. An improvement tool to compare performance to another organization
6. A symbol for a task
8. Flat sum amount that patient owes with each visit
9. Graphical representation of activities
10. The willingness to change
12. NAHAM model - activities prior to service
14. Failing to deliver what the customer expects
16. Customer feedback obtained from a survey

Crossword Puzzle Answers

How did you do?



Across:

1. JCAHO
2. FutureDevelopment
3. KPI
6. SixSigma
7. Compliance
11. MPI
13. Competence
15. Passive
16. Active

Down:

2. FOCUSPDCA
4. ProcessMap
5. Benchmarking
6. Square
8. Copayment
10. Adaptability
12. PreEncounter
14. Defect

Word Puzzle
A fun way to test your knowledge

4	11	12	12		4	16	35	28	32	34	32	4	12	28	32	2	6			
13	35	2	15	2	28	16	37		13	35	2	34	16	37	37	32	2	6	12	3
4	2	15	15	32	28	15	16	6	28											

Written notification indicating Medicare may not pay for services

12	B	6	

Alternative patient name

12	3	32	12	37	

Computer based training

4	B	28	

Certified Healthcare Access Associate

4	11	12	12	

Statute governing when and how a patient may be refused treatment

16	15	28	12	3	12	

Explanation of benefits

16	2	B	

Competent adult who is responsible for the bill

G	U	12	35	12	6	28
2	35					

Federal law requiring security of health data

11	32	13	12	12	

Health Maintenance Organization

11	15	2	

A tangible or intangible reward

32	6	4	16	6	28	32
V	16					

Focuses on maximizing process speed

3	16	12	6	

Promotes excellence in the management of Patient Access

6	12	11	12	15	

A process of checking the work of an "equal"

13	16	16	35		35	16
V	32	16	W			

The first step in the NAHAM model

13	35	16	-	16	6	4
2	U	6	28	16	35	

Step-by-step instructions on how to perform a task

13	35	2	4	16	D	U
35	16					

Measure of labor output

13	35	2	D	U	4	28
32	V	32	28	Y		

Type of written survey

Q	U	16	37	28	32	2
6	6	12	32	35	16	

The underlying reason for a problem

35	2	2	28		4	12
U	37	16				

The right information to provide an easy journey

W	12	Y	34	32	6	D
32	6	G				

Word Puzzle
How did you do?

4	11	12	12		4	16	35	28	32	34	32	4	12	28	32	2	6			
13	35	2	15	2	28	16	37		13	35	2	34	16	37	37	32	2	6	12	3
4	2	15	15	32	28	15	16	6	28											

Written notification indicating Medicare may not pay for services

12 A	B	6 N	

Alternative patient name

12 A	3 L	32 I	12 A	37 S	

Computer based training

4 C	B	28 T	

Certified Healthcare Access Associate

4 C	11 H	12 A	12 A	

Statute governing when and how a patient may be refused treatment

16 E	15 M	28 T	12 A	3 L	12 A	

Explanation of benefits

16 E	2 O	B	

Competent adult who is responsible for the bill

G	U	12 A	35 R	12 A	6 N	28 T
2 O	35 R					

Federal law requiring security of health data

11 H	32 I	13 P	12 A	12 A	

Health Maintenance Organization

11 H	15 M	2 O	

A tangible or intangible reward

32 I	6 N	4 C	16 E	6 N	28 T	32 I
V	16 E					

Focuses on maximizing process speed

3 L	16 E	12 A	6 N	

Promotes excellence in the management of Patient Access

6 N	12 A	11 H	12 A	15 M	

A process of checking the work of an "equal"

13 P	16 E	16 E	35 R		35 R	16 E
V	32 I	16 E	W			

The first step in the NAHAM model

13 P	35 R	16 E	-	16 E	6 N	4 C
2 O	U	6 N	28 T	16 E	35 R	

Step-by-step instructions on how to perform a task

13 P	35 R	2 O	4 C	16 E	D	U
35 R	16 E					

Measure of labor output

13 P	35 R	2 O	D	U	4 C	28 T
32 I	V	32 I	28 T	Y		

Type of written survey

Q	U	16 E	37 S	28 T	32 I	2 O
6 N	6 N	12 A	32 I	35 R	16 E	

The underlying reason for a problem

35 R	2 O	2 O	28 T		4 C	12 A
U	37 S	16 E				

The right information to provide an easy journey

W	12 A	Y	34 F	32 I	6 N	D
32 I	6 N	G				

RESOURCES

Behavioral competencies

Books

- Calm in the Face of Conflict: 12 Powerful Strategies to Help You Think through Problems, Decisions, and Conflicts by Cheryl A. Cage
- Dealing With Stress At Work by Bob, Ph.D. Nelson, e-document available at Amazon.com
- Thinking on Your Feet (50-minute Series) by Marlene Caroselli
- Adapting to Change: Making It Work for You by Carol Kinsey Goman
- Fish! Sticks: A Remarkable Way to Adapt to Changing Times and Keep Your Work Fresh by Stephen C. Lundin, John Christensen, Harry Paul
- Managing Personal Change: Moving Through Personal Transition (50-minute Series) by Cynthia D. Scott, Ph.D., Dennis T. Jaffe, Ph.D.
- The Employee Handbook of New Work Habits for a Radically Changing World: 13 Ground Rules for Job Success in the Information Age by Price Pritchett
- Who Moved My Cheese? by Spencer Johnson
- 104 Activities That Build: Self-esteem, Teamwork, Communication, Anger Management, Self-discovery, and Coping Skills by Alanna E. Jones
- Improving Peer Relationships: Achieving Results Informally (50-minute Series) by Norman C. Hill
- People Styles at Work: Making Bad Relationships Good and Good Relationships Better by Robert Bolton and Dorothy Grover Bolton
- The Power of We: Succeeding Through Partnerships by Jonathan Tisch
- The Relationship Edge in Business: Connecting with Customers and Colleagues When It Counts by Jerry Acuff
- 1001 Ways to Take Initiative at Work by Bob Nelson
- Effective Listening Skills by Art James, Dennis Kratz
- How to Speak and Listen Effectively by Harvey A. Robbins
- Listening: The Forgotten Skill : A Self-Teaching Guide by Madelyn Burley-Allen
- The Business of Listening: A Practical Guide to Effective Listening (50-minute Series) by Diane Bonet
- Getting Organized: Learning How to Focus, Organize and Prioritize by Chris Crouch
- Getting Things Done: The Art of Stress-Free Productivity by David Allen
- Plan Your Work/Work Your Plan: Secrets for More Productive Planning (50-minute Series) by James R. Sherman
- Time Tactics of Very Successful People by B. Eugene Griessman
- Conversationally Speaking : Tested New Ways to Increase Your Personal and Social Effectiveness by Alan Garner
- How to Get Your Point Across in 30 Seconds or Less by Milo O. Frank
- The Power of Self-Management: Achieving Success in Your Healthcare Career by Michael H. Cohen

- The Self-Management Workshop: Helping People Take Control of Their Lives and Their Work - A Trainer's Guide by Donald H. Weiss, Ph.D.
- Why We Do What We Do: Understanding Self-Motivation by Edward L. Deci, Richard Flaste
- Goals and Goal Setting (50-minute Series) by Larrie A. Rouillard
- How to Achieve Your Goals by Carol Carter, Joyce Bishop, Sarah Lyman Kravits
- The Magic Lamp - Goal Setting for People who Hate Setting Goals by Keith Ellis
- Integrity by Stephen L. Carter
- Where in the World is Integrity? by Bruce B. Roberts, Craig D. Rice, Joe E. Smith
- Proofreading Skills: Tips, Techniques and Tactics (50-Minutes Series) by Debra A. Smith, Helen R. Sutton
- Creative Problem Solving: The Door to Individual Success and Change by Thomas W. Dombroski

Seminars

- Handling Difficult and Demanding Customers: A Communication Course, National Seminar Group, www.natsem.com
- How to be a Super Communicator, National Seminar Group, www.natsem.com
- Powerful Communication Skills for Women, National Seminar Group, www.natsem.com

Websites

- www.thechangeagent.com
- www.teambuildinginc.com
- www.agelesslearner.com
- www.speaking.com
- www.about-goal-setting.com
- www.mindtools.com

Other resources

Websites:

- www.isixsigma.com

GLOSSARY OF TERMS

Accepting Assignment	When a provider agrees to accept the allowable charges as the full fee and cannot charge the patient the difference between the insurance payment and the provider's normal fee.
Access	The patient's ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.
Account Number	A number assigned to each account. This number is used to identify the account and all charges and payments received.
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 health care delivered to patients experiencing acute illness or trauma. Acute care is generally short-term (< 30 days).
Add-Ons	Patients who are scheduled for services less than 24 hours in advance of the actual service time.
Adjustor	Insurance company representative.
Administrative Costs	Costs associated with creating and submitting a bill for services, which could include: registration, utilization review, coding, billing, and collection expenses.
Admission Authorization	The process of third party payer notification of urgent/emergent inpatient admission within specified time as determined by payers (usually 24-48 hours or next business day).
Admission Date	The first date the patient entered the hospital for a specific visit.
Admitting Diagnosis	Word, phrase, or International Classification of Disease (ICD9) code used by the admitting physician to identify a condition or disease from which a patient suffers and for which the patient needs or seeks medical care.
Admitting Physician	The physician who writes the order for the patient to be admitted to the hospital. This physician must have admitting privileges at the facility providing the healthcare services.
Advance Beneficiary Notice (ABN)	A notice that a care provider should give a Medicare beneficiary to sign if the services being provided may not be considered medically necessary and Medicare may not pay for them. The advanced beneficiary notice (ABN) allows the beneficiary to make an informed decision prior to services whether or not he/she wishes to receive services. ABNs are not routinely given to emergency department patients.
Advance Directive	An advance directive is a written instruction relating to the provision of healthcare when a patient is incapacitated. It could include appointing someone to make medical decisions, a statement expressing the patient's wishes about anatomical gifts (i.e. organ donation), and general statements about whether or not life-

	sustaining treatments should be withheld or withdrawn.
Adverse Selection	Among applicants for a given group or individual program, the tendency for those with an impaired health status, or who are prone to higher than average utilization of benefits to be enrolled in disproportionate numbers and lower deductible plans.
Alias	An alias is a name by which the patient is also "known as", or formerly known as.
All Patient Diagnosis Related Groups Assignment of Benefits (APDRG)	A prospective hospital claims reimbursement system currently utilized by the federal government Medicaid program and the states of New York and New Jersey. APDRGs were designed to describe the complete cross section of patients seen in acute care hospitals. Approximately 639 APDRGs are defined according to the principal diagnosis, secondary diagnoses, procedures, age, birth weight, sex, discharge status. Each category has an established fixed reimbursement rate based on average cost of treatment within a geographic area. APRDRG's were developed to quantify the difference in demographic groups and clinical risk factors for patients treated in hospitals. This proprietary grouping system's (i.e. 3M) purpose is to obtain fair and accurate statistical comparisons between disparate populations and groups. Unlike the Diagnosis Related Group (DRG) reimbursement system which is intended to capture resource utilization intensity, the APRDRG system captures and relates the Severity of Illness and Risk of Mortality factors present as a result of a patient's disease and disorders and the interaction of those disorders. A form is signed by the Patient giving the healthcare provider authority to bill his/her insurance plan and receive payment. The form is generally presented and signed at the time of registration.
Alphanumeric	Letters, numbers, punctuation marks and mathematical symbols, as opposed to "numeric" which is numbers only. Term typically related to the kind of data accepted in a computer field or in coding.
Ambulatory Care Patient	Patient receives medical or surgical care in an outpatient setting that involves a broader, less specialized range of care. Ambulatory patients are generally able to walk and are not confined to a bed. In a hospital setting, ambulatory care generally refers to healthcare services provided on an outpatient basis.
Ambulatory Payment Classification (APC)	A system of averaging and bundling using Current Procedural Terminology (CPT) procedure codes, Healthcare Common Procedure Coding System (HCPCS) Level II, and revenue codes submitted for payment. The APC system utilizes groups of CPT codes based on clinical and resource similarity and establishes payment rates for each APC grouping. The 650 + APCs are divided by significant procedures, medical services, ancillary services and partial hospitalization services. The APCs are similar clinically, by resources used and cost. A payment rate has been established for each APC.

	System similar to Diagnosis Related Group's (DRG) to be used for outpatients. Current scheme includes 346 APCs broken into categories of Medical, Diagnostic, Surgical, and Radiology and include Emergency Department and partial hospitalization services.
Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical, diagnostic, and therapeutic services are provided on an outpatient ambulatory basis.
Ancillary Services	A unit of the hospital, other than a nursing unit, which provides medical services such as diagnostic testing, therapeutic procedures, or dispenses medical products, such as medications or medical/surgical supplies. Examples: Laboratory, Medical Imaging, Physical Therapy, Pharmacy. Ancillary is used to describe diagnostic or therapeutic services, such as laboratory, radiology, pharmacy, or physical therapy, performed by departments that do not have inpatient beds.
Annual Maximum Benefit Amount Deductible	The maximum dollar amount set by a Managed Care Organization (MCO) that limits the total amount the plan must pay for all health care services provided to a subscriber in a year. A deductible is the set amount, per benefit year or period, the third party payer designates as the patient/guarantor's responsibility. Usually the deductible must be paid before benefits will be paid by the payer. The maximum dollar amount set by an MCO that limits the total amount the plan must pay for all health care services provided to a subscriber in a year.
Appeal	An appeal is a special kind of complaint made when a beneficiary or provider disagrees with decisions about health care services – typically related to payment issues. There is usually a special process used to appeal payer decisions.
Appropriate Care	A diagnostic or treatment measure whose expected health benefits exceed its expected health risks by a wide enough margin to justify the measure.
Assignment of Benefits	Written authorization from the policyholder for their insurance company to pay benefits directly to the care provider. Normally acquired at the time of admission or registration.
Attending Physician	The physician who writes outpatient orders for tests, or supervises the patient's care during an inpatient stay.
Authorization	Approval obtained from an insurance carrier for a service that represents an agreement for payment.
Authorization to Release Medical Information	The form authorizing to release information from the medical records to doctors, hospitals, insurance, other agencies, etc.
Average Daily Census	The average number of inpatients maintained in the hospital for each day for a specific period of time.
Average Length of Stay	The average number of days of service rendered to each patient during a specific time period.
Bad Debt	An accounts receivable that is regarded as uncollectible and is

	charged as a credit loss even though the patient has the ability to pay.
Balance Billing	The practice of billing a patient for the fee amount remaining after insurer payment and co-payment have been made.
Batch Processing	Information technology term referring to grouping similar input items and then processing them together during a single machine run.
Behavioral Health	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
Beneficiary	Person designated to receive the proceeds of an insurance policy; the insured under a health insurance policy. Also referred to as eligible; enrollee; or member. Any person eligible as either a subscriber or a dependent for a managed care service in accordance with a contract.
Benefit Period	The number of days that Medicare covers care in hospitals and skilled nursing facilities are measured in benefit periods. A benefit period begins on the first day of services of a patient in a hospital or skilled nursing facility and ends 60 days after discharge from the hospital or skilled nursing facility if 60 days has not been interrupted by skilled care in any other facility. There is no limit to the number of benefit periods. The beneficiary must pay the inpatient hospital deductible for each benefit period.
Benefit Verification	The process of confirming benefits for services. The process of verification of demographic, financial and insurance information that is obtained either through pre-registration or scheduling is second in importance only to the process of pre-certification. Truly, the two processes must go hand-in-hand to successfully defend the financial viability of the provider. Contact should be made with the insurance company. Benefits may vary significantly with the diagnosis. Together with pre-certification, verified coverage provides the hospital with essential information, in advance, to determine appropriate utilization review needs and alternative financial arrangements required.
Benefit Verification Period	The way that Medicare measures the use of hospital and skilled nursing facility services. A benefit period begins on the day of admission to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. After the 60 days have elapsed a new benefit period begins. The beneficiary must pay the inpatient hospital deductible for each benefit period. There is no limit on the number of covered benefit periods.
Birthday Rule	A rule used to determine whose insurance is primary for a child covered under both parents' insurance. Both insurance carriers must follow the birthday rule. The parent whose birthday falls earliest in the calendar year becomes the primary insurance and the other would be secondary. If both parents are born on the same day, the parent whose insurance has been in effect the

	longest is the primary insurance.
Birthing Center	A facility, other than a hospital's maternity facility or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care for newborn infants.
Capitation	A fixed rate of payment to cover a specified set of health services. The rate is usually provided on a per member/per month basis regardless of the services that are actually rendered.
Carrier	A health insurance plan or another entity that processes and pays healthcare bills. May be called a third party payer, payer, carrier, or insurer. These terms are interchangeable. Carrier may also refer to an organization contracted with the Centers for Medicare and Medicaid Services (CMS) to process and pay Medicare Part B claims.
Carve Out	A decision to separately purchase a service, which is typically a part of an indemnity of a Health Maintenance Organization (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.
Case Management	A process of identifying plan members with special health care needs, developing a health care strategy that meets those needs, and coordinating and monitoring the care, with the ultimate goal of achieving the optimum health care 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.
Case Mix Index (CMI)	Case Mix Index is determined by dividing the sum of all Diagnosis Related Group (DRG) relative weights for every DRG used by Medicare patients by the total number of Medicare inpatient cases for the hospital. The CMI is adjusted each fiscal year for all hospitals based upon the case mix data received. Case mix and complexity can be analyzed and monitored in relation to cost and utilization of services. The CMI measures the cost of a hospital's Medicare patient mix in relation to the cost of all Medicare patients. The CMI is used to adjust the hospital base rate, which is a factor in computing the total hospital payment under a Prospective Payment System (PPS).
Census Verification	The process of accurately accounting for all Admission-Discharge-Transfer (ADT) activity within or across entities.
Centers for Disease Control and Prevention (CDC)	The Centers for Disease Control and Prevention (CDC) is one of the major operating components of the Department of Health and Human Services. The CDC works with partners throughout the nation and the world to: monitor health, detect and investigate health problems, conduct research to enhance prevention, develop

	and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training. The CDC's mission is to promote health and quality of life by preventing and controlling disease, injury, and disability.
Centers for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. CMS is responsible for the administration of the Medicare and other health-related programs as well as Medicaid and the State Children's Health Insurance Program (SCHIP), which serves many of the uninsured children in the United States.
Charge Description Master (CDM)	Charge Description Master is a master file in the computer system listing the services provided at the hospital that have an assigned charge. A unique number is assigned to each charge. Also included is a description of the service, a code for the department rendering care, applicable HCPCS/ Healthcare Common Procedure Coding System/Current Procedural Terminology (CPT) code, and other information.
Charity Care	Financial Assistance program available to qualifying patients based on financial need.
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	Civilian Health and Medical Program of the Uniformed Services has been replaced by TRICARE.
Claim	An itemized statement of health care services and their costs provided by a hospital, physician's office or other provider facility. Claims are submitted to the insurer or managed care plan by either the plan member or the provider for payment of the costs incurred.
Claimant	The person or entity submitting a claim.
Claims Administration	Employees in the claims administration department who consider all the information pertinent to a claim and make decisions about the Managed Care Organization's (MCO) payment of the claim. Also known as claims analysts.
Clinic	A medical or surgical specialty unit of a hospital or hospitals' free standing facility where a patient is seen on an ambulatory basis but remains the hospital's responsibility for ongoing care and disposition.
Clinical Data Repository (CDR)	The process of receiving, reviewing, adjudicating and processing claims.
Clinical Integration	A type of operational integration that enables patients to receive a variety of health services from the same organization or entity, which streamlines administrative processes and increases the potential for the delivery of high-quality health care.
Closed Access	A provision which specifies that plan members must obtain medical services only from network providers through a primary care physician to receive benefits.
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 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
Co-insurance	Co-insurance is another amount the third party payer can identify as the Patient/Guarantor's responsibility. Coinsurance is usually a percentage of the total billed amount.
Co-insurance Days (CID)	A method of cost sharing in which the subscriber is responsible for a specified percentage of the cost of healthcare under fee-for-service plans. Plans where the insured is responsible for 20% while the insurance will cover 80% are fairly typical. Frequently there is a maximum amount the insured is required to pay, called a stop loss amount. Coinsurance Days (CID) relate to Part A Medicare benefits. For each day of hospitalization over 60 days and up to the 90th day, a coinsurance payment of one-quarter of the inpatient deductible is due.
Collection Agency	An outside vendor that collects payment on hospital accounts under contract with the hospital. The hospital refers an account to a collection agency when they are unable to collect the account themselves. The collection agency charges a fee for moneys collected usually based on a percentage of the amount collected.
Commercial Insurance	This term is used to identify several types of insurance policies other than Managed Care. Most policies provide coverage in the following four areas: Hospitalization, Surgery, Minor Medical and Major Medical.
Common Working File (CWF)	A national file of Medicare claims.
Co-morbidity	A pre-existing condition that will, because of its presence with a specific principal diagnosis, cause an increased length of stay by at least one day. Also referred to as a "substantial complication".
Compliance	The act of complying with a request, demand or regulation. Also known as Corporate Integrity. Conducting ourselves within the law in all our business practices. Addressing such issues as, but not limited to: Fraud & Abuse, Billing practices, Antitrust, Quality of Care, Managed Care, Bribes & Improper payments, Conflicts of Interest, Environmental Concerns, Copyright & Software Licensing.
Consent	Voluntary permission or agreement.
Consent to Treat	The patient's or legally responsible party's signed authorization for a hospital to provide medical care and treatment.
Conservator	A conservator is a person, official, or institution designated to take over and protect the interests of an incompetent person. This includes being responsible for paying the individual's healthcare bills. A guardian may also be the conservator.
Consolidated Omnibus Budget	The Consolidated Omnibus Budget Reconciliation Act of 1985 requires employers to permit employees or family members to

Reconciliation Act (COBRA)	continue their group health insurance coverage at their own expense, but at group rates, if they lose coverage because of loss of employment, divorce, death of the supporting spouse, or other designated events. Former employees may be required to pay a two percent administrative fee in addition to the full premium; this coverage generally lasts a maximum of 18 months.
Consulting Physician	Physician, other than the admitting or attending physician, who has been asked to participate or provide counsel in a particular episode of care.
Consumer Driven Healthcare	Refers to health plans in which individuals have a personal health savings account (HSA) or a health reimbursement account (HRA) from which they pay medical expenses.
Continuum of Care	The scope of healthcare services provided to an individual during a single episode of illness or for multiple conditions over a lifetime.
Contract	A legal agreement between a payor and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period.
Contract Provider	Any hospital, skilled nursing facility, extended care facility, individual, organization, or agency licensed that has a contractual arrangement with an insurer for the provision of services under an insurance contract.
Contractual Allowance	The amount that is not paid, due to a reimbursement agreement, is considered an adjustment or contractual allowance. This is an allowance that may not be paid by any party. It is based on a contractual agreement between the third party payer and the hospital, so it is called the contractual allowance.
Coordination of Benefits (COB)	The determination of primary, secondary, and tertiary payers must be completed either at registration or through the insurance verification process. Determining the priority of payment of benefits to eliminate duplicate payments is called coordination of benefits (COB). Applies when an insured is covered by more than one policy. It stipulates that the involved insurers will each pay their share of the insured's total covered expenses, but will not pay, in the total, more than those expenses.
Co-pay	A co-pay is a cost sharing arrangement where the patient/guarantor is responsible for a defined amount for a specific type of service. The co-pay is usually paid at the time of service.
Co-pay CMS 1500	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 (HMO) and referred provider organizations (PPO) 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. CMS 1500 is used by physicians and other

	clinicians.
Corporate Person Index (CPI)	Corporate Person Index (CPI) or Master Patient Index (MPI) houses the Patient's medical record number and other key demographic information.
Courtesy Discharge	When a patient is discharged from the hospital without settling his/her account and is to be billed later for the balance of the bill.
Covered Benefit	A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.
Credentialing	The process of reviewing a practitioner's training, experience, or demonstrated ability, for the purpose of determining if they meet the criteria to authorize the practitioner to practice medicine.
Critical Access Hospitals (CAH)	Hospitals defined in rural areas designated for 25 inpatient beds which also serve as swing or skilled nursing beds.
Current Procedural Terminology (CPT)	Current Procedural Terminology (CPT) represents Level I Healthcare Common Procedure Coding System (HCPCS), or the Physicians Current Procedure Terminology, which is authored by the American Medical Association, or AMA.
Current Procedural Terminology, 4th Edition (CPT-4)	Current Procedural Terminology, 4th edition – Comprehensive listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. This provides a uniform language that will accurately describe medical, surgical, and diagnostic services and will thereby provide an effective means for reliable nationwide communication among physicians, patients and third parties.
Custodial Care	Care that primarily supports and maintains the patient's condition without active or aggressive medical treatment. The patient is mentally or physically disabled and/or the condition is expected to be prolonged. Custodial Care facilities provide long term room, board, and other personal assistance services, but do not provide medical services.
Deductible	A fixed sum that a beneficiary must contribute towards the cost of their healthcare before insurance benefits begin.
Default	Term used when the system is programmed to place a predetermined value in a field that is left blank.
Dependent	A person, other than the subscriber, who is covered under the insurance membership. If a working spouse covers you and/or the children on his/her policy, you would be the dependent(s). Dependent is a person who depends on someone else for support, such as a child or elderly parent. A minor who is a dependent cannot be the guarantor. The guarantor for a dependent minor must be an adult.

Deposit	The amount of money a healthcare provider requires prior to rendering service. The amount of the deposit is typically a percentage of the estimate of the patient's liability (the charges remaining after all insurance companies have paid).
Designated Code Set	A Medical Code set or an administrative code set that Health and Human Services (HHS) has designated for use in one of more of the HIPAA standards.
Designated Record Set	For covered health care providers (under HIPAA), designated records sets include, at a minimum, the medical record and billing record about individuals maintained by or for the provider. In addition to these records, designated records sets include any other group of records that are used.
Diagnosis Related Group (DRG)	System for classification for over 490 diagnoses based on patterns in resource consumption and length of stay. Used in many prospective payment plans including Medicare. DRGs classify all human diseases according to the affected organ system, surgical procedures performed, disposition, and gender of the Patient. Currently, there are over 500 active DRGs within the inpatient prospective pricing methodology. A flat rate is paid per inpatient stay based on the assigned DRG.
Discharge Planning	Medical personnel of the health plan work with the attending physician and hospital staff to assess alternatives to hospitalization, evaluate appropriate settings for care and arrange for discharge of a patient, including planning for subsequent care at home or in a skilled nursing facility.
Discounted Fee-For-Service	An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount.
Donor	One from whom blood, tissue or an organ is taken for use in a transfusion or transplant.
Durable Medical Equipment (DME)	Durable medical equipment typically withstands repeated use, improves function or retards further deterioration of a physical condition, and primarily provides a medical function. (Ex: Hospital bed; wheelchair)
Durable Power of Attorney for Healthcare	A legally assigned individual that is empowered to make medical treatment decisions on the patient's behalf if the patient is incapacitated and cannot speak for him/herself. Also known as a Healthcare Agent or Proxy. See Advanced Directives.
Effective Dates - Insurance	The beginning and ending dates for which third-party financial responsibility is enforced. Any service dates before or after these dates will not be covered by a particular third-party.
Electronic Media	Electronic media are the storage and transmission tools used to store and deliver information or data and utilizes electronics or electromechanical energy for the end user to access the content
Eligibility	The act of confirming a person's status with the employer or union is called an eligibility check. A person who is entitled to benefits according to an employer or union, and is currently covered by

	insurance.
Eligible Dependent	A dependent of a covered employee who meets the requirements specified in the group contract to qualify for coverage and for whom premium payment is made.
Eligible Expenses	Reasonable and customary charges, or the agreed upon fee for health services and supplies covered under a health plan.
Email	Email (or Electronic mail) is a telecommunications system that enables users to send messages prepared on a computer to another computer user. Telephone lines are generally used to send the signal from terminal to terminal. Files may be sent via email but the recipient must have compatible software to open them.
Emancipation	Legal term that means a child is no longer under the control of the parent. For example, a 16 your old female is considered emancipated if married. The definition varies from state to state. Some minors are emancipated, meaning they have been released from their parents' control and supervision and are responsible for themselves. Emancipated minors are their own guarantors.
Emergency Care Patient	Patients examined on an unscheduled basis for immediate diagnosis and treatment in the emergency facilities of the hospital. They are not admitted for inpatient service. An individual who receives immediate medical attention through the Emergency department.
Emergency Medical Treatment and Active Labor Act (EMTALA)	The Emergency Medical Treatment and Active Labor Act is a statute that governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition. Also known as the Anti-dumping law.
Employer Group Health Plan (EGHP)	Health Insurance provided through an employer.
Encounter	A face-to face meeting between a covered person and a health care provider where services are provided.
End Stage Renal Disease (ESRD)	End stage renal disease (ESRD) is a term used to describe a kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. Patients receiving care for this disease are eligible for Medicare, if they meet other requirements and if they apply.
Enrolled Group	Persons with the same employer or with membership in an organization in common, who are enrolled collectively in a health plan. Often, there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before coverage is available.
Enrollee	Any person eligible as either a subscriber or a dependent for service in accordance with a contract. Also refers to a member in a database. (Also beneficiary; individual; member)
Episode	Also known as a “Visit,” an “Episode of Care,” or an encounter with the health system. The visit is initiated by a request for service.
Evidence of Coverage (EOC)	An evidence of coverage (EOC) is an addendum of the group plan contract and constitutes only a summary of the terms and conditions

	of coverage. If there is a conflict between the EOC and the group plan contract, the group plan contract will prevail.
Exclusions	Specific conditions or circumstances listed in the contract or employee benefit plan for which the policy or plan will not provide benefit payments.
Exhaustion of Benefits	The maximum contract amount payable by the insurance carrier for services. Many payers have a calendar year and a lifetime maximum limit on benefits they will pay for. Once the maximum has been reached, the benefits have been exhausted. There are no more funds available for coverage of any further services.
Explanation of Benefits (EOB)	The statement sent to a covered person by a health plan, listing services provided, benefits paid on the claim, deductible and/or co-payment amounts, and any remaining balance due. Explanation codes on the EOB denote the amount of the member's liability.
FAQ	Frequently Asked Question
Fee Schedule	A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures. Usually associated with ancillary services such as lab or radiology.
Fee-for-service	The traditional healthcare payment system, under which physicians and other providers receive a payment for each unit of service provided.
Financial Class	A code that identifies the primary insurance for an account. Financial class codes are related to insurance plan codes.
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.
Fiscal Intermediary (FI)	Fiscal intermediary generally refers to an organization contracted with the Health Care Financing Administration (HCFA) Centers for Medicare and Medicaid Services (CMS) to process and pay Medicare UB-04 claims.
Fiscal Year	An organization's twelve-month accounting period; does not necessarily coincide with the calendar year. In many healthcare organizations the fiscal year is July 1 through June 30.
Form Locator	Form Locator (FL) 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.
Gatekeeper	A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the gatekeeper must reauthorize the visit unless there is an emergency.

Group Health Plan	Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity such as AARP.
Guarantor	The responsible party for payment of services that may not be covered by a third party.
Guardian	A person who is responsible for the care and/or property of another.
HCFA 1450	AKA UB92 – Medicare Part A claim filing form used for inpatient and outpatient encounters. It is standardized for use when submitting claims for Medicare A services.
HCFA 1500	Standardized form used to submit claims for Medicare Part B services.
Health Care Financing Administration (HCFA)	Health Care Financing Administration (HCFA) was the name of the administrative branch within the Department of Health and Human Service that was responsible for the Medicare and Medicaid programs. Now called Centers for Medicare and Medicaid Services (CMS).
Health Employer Data and Information Set (HEDIS)	A set of performance measures designed to standardize the way health plans report data to employers.
Healthcare Common Procedure Coding System (HCPCS)	The Healthcare Common Procedure Coding System (HCPCS) is a medical code set using Current Procedural Terminology 4 (CPT 4), alphanumeric, and local codes to identify health care procedures, equipment and supplies for claims submission. It is maintained by the Centers for Medicare and Medicaid Services (CMS) and has been selected for use in Health Insurance Portability and Accountability Act of 1996 (HIPAA) transactions. HCPCS is a three level coding system used to describe procedures, tests, and supplies. However, since the HIPAA regulation required standardization of codes, only two levels are used today. Current Procedural Terminology (CPT) represents Level I HCPCS, or the Physicians Current Procedure Terminology, which is authored by the American Medical Association (AMA).
Health and Human Services (HHS)	Administrative department of the federal government with responsibility for the Centers for Medicare and Medicaid Services (CMS), Health Care Financing Administration (HCFA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Health Insurance Claim Number (HICN)	Health Insurance Claim Number – official name for Medicare Number.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that made a number of changes which have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title I, subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards;

	to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.
Health Maintenance Organizations (HMO)	Health Maintenance Organizations (HMO's) offer prepaid, comprehensive health coverage to their enrollees by contracting with hospitals, physicians, and other health professionals for their services. HMO enrollees choose among contracted providers for all health services. Membership is contracted for a specified time period.
Help Screen	Information screens that can be accessed for data fields in hospital information systems, typically consisting of a description of the field and allowable values for the field.
Hospice	Care that can be provided within the home for terminally ill patients and their families. Hospice provides a support system to patients and families who choose to share their last days together in the comfort of their home or other like setting. Hospice care is a covered service under the Medicare program.
The International Classification of Disease, Clinical Modification (ICD CM)	ICD-9-CM is based on the official version of the World Health Organization's Ninth Revision International Classification of Diseases (ICD-9), the most widely used classification system for the study of disease in the world today. Hospitals and other healthcare providers use ICD CM codes to report clinical information required for participation in various federally funded health programs such as Medicare, Medicaid, and Maternal and Child Health. Virtually every third party payor requires the submission of ICD CM codes to describe diagnosis, symptoms, conditions, or complaints for billing purposes. They are also used in preparing statistics on morbidity and mortality, and on utilization of healthcare services, and in health planning. In ICD-10, conditions have been grouped in a way that was felt to be most suitable for general epidemiological purposes and the evaluation of health care. ICD-10 was first used for the coding of national mortality data in 1994. The World Health Statistics Annual, 1996, published in early 1998, contains ICD-10 data for the first time.
ICON	A small picture on a computer screen representing a function or program. They make computers easier to use by allowing the user to click with a mouse rather than typing in commands or using menus.
Important Message from Medicare Indemnity (IMM)	Medicare explanation to patients regarding their discharge and their discharge rights, including instructions on how to appeal if they feel they are being discharged too quickly. The document must be delivered within 2 calendar days of admission and a copy followed up as far in advance as possible before discharge, but no more that 2 calendar days before discharge.

Indemnity	A health insurance plan in which patients may select any doctor or hospital and providers bill the patient or the insurance company their normal fees for their services. Providers have no relationship with the health plan. Coverage is usually provided only for diagnostic tests or conditions caused by disease, illness or injury. Routine screening or will visits are not always covered under traditional indemnity plans. ("Fee-for-service" is sometimes used as a synonym.)
Independent Practice Association (IPA)	An Independent Practice Association (IPA) is a health maintenance organization delivery model in which the Health Maintenance Organization (HMO) contracts with a physician organization which, in turn, contracts with individual physicians. The IPA physicians practice in their own offices and continue to see fee-for-service patients. The HMO reimburses the IPA on a capitated basis; however, the IPA usually reimburses the physicians on a fee-for-service basis. This type of system combines prepayment with the traditional means of delivering health care.
Inpatient	A patient who is admitted for an expected overnight stay or for at least 24 hours and is provided with room, board, and continuous general nursing services for diagnostic, surgical or medical reasons. An inpatient must meet intensity of service/severity of illness ("IS/SI") appropriateness criteria. The physician's intent/order at the time of admission must have been for an inpatient admission. If a patient is expected to stay overnight after an invasive or surgical procedure and meets IS/SI criteria, the patient is admitted as an inpatient. An individual who receives healthcare services while admitted to the hospital overnight or longer.
Insurance Verification	The process of determining coverage availability and benefits of coverage.
Insured	The individual who is the holder of healthcare coverage through an insurance policy. Also employer, private health plan, or other payer can be called the insured, subscriber, policyholder or subscriber or sponsor.
Insurer	A health insurance plan or another entity that processes and pays healthcare bills may be called a third party payer, payer, carrier, or insurer. These terms are interchangeable.
Interface	A program that passes information from one system to another.
Intermediary	A private business, typically an insurance company, which contract with Centers for Medicare and Medicaid Services (CMS) to receive, review and pay hospital and other institutional provider benefit claims.
Internet	The Internet, or World Wide Web (www), is an on-line computer network connecting companies, universities, government agencies, healthcare systems, networks, and users, etc. The Internet provides users the ability to access remote computers and send and retrieve files.

Itemized Statement	An itemized statement is the record maintained by the health facility, hospital or physician's office that details the charges made for services rendered to patients and shall indicate whether an assignment of benefits has been obtained
Joint Commission on Accreditation of Healthcare Organizations. (JCAHO)	The Joint Commission is an independent, not-for-profit organization, and the nation's oldest and largest standards setting and health care accrediting body. The mission of JCAHO is to improve the quality of health care for the public by providing accreditation and related services that support performance improvement in health care organizations.
Length of Stay (LOS)	Length of stay (LOS) is just that, the length of a patient's stay in a hospital or other health facility. Length of stay is only calculated for inpatients. The number of days the patient is in the hospital is totaled to determine the length of stay. Only the admission date is counted; the discharge date is not included in the count. For example, if the patient was admitted on May 1 and discharged on May 5, count May 1, May 2, May 3, and May 4; for a total of 4 days.
Liability Insurance	Refers to insurance coverage (including a self-insured plan) that provides payment based on legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, malpractice insurance, product liability insurance and general liability insurance.
Lifetime Maximum	The maximum amount of benefit paid by the insurance company per insured. Once this lifetime maximum has been exhausted, the insurance company will not pay any benefits.
Lifetime Reserve Days (LRD)	Lifetime reserve days (LRD) is the term for Medicare Part A coverage that entitles the beneficiary to sixty days of inpatient coverage beyond the coinsurance day benefit period.
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.
Managed Care	A system where care is sharply controlled through the use of a "gatekeeper" or prior authorization process. This type of plan usually involves a Preferred provider organization (PPO) in which the patient has to use a provider contracted with the insurer to accept an agreed on fee.
Managed Care Organization (MCO)	Managed Care Organization is an organization of medical doctors, hospitals, and other health care providers who have covenanted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

Managed Healthcare	A system of healthcare delivery that tries to manage the cost of healthcare, the quality of that healthcare and access to that care.
Master Patient Index (MPI)	The Master Patient Index (MPI) is a comprehensive list of all patients and their key identifiers. It may also be known as Enterprise Master Person Index (EMPI) when used to link information from a variety of systems and providers within an independent healthcare network (IHN). The MPI or Corporate Person Index (CPI) houses the Patient's medical record number and other key demographic information.
Medicaid	A joint Federal and State program that is administered and operated individually by each participating state government. Provides medical benefits to some people with low-income and limited resources. Since the state government administers it, regulations and benefits vary from state to state. Each state may adopt a different name for the program. For example, in California, the program is called Medi-Cal.
Medical Record	The medical record is a clinical record of the services, results of tests, and progress notes associated with a patient visit.
Medical Record Number	A number that uniquely identifies a patient. Used as the primary identifier on the patient's chart and other medical documentation.
Medically Necessary	The frequency, extent and types of service or supplies that represent appropriate medical care and are generally accepted by qualified professionals as reasonable and adequate for the diagnosis and treatment of illness, injury, or maternity care. Many payors have their own panel of professionals and experts that determine medical necessity. Many payors have computer programs that compare the World Health Organization's Ninth Revision International Classification of Diseases (ICD-9) diagnosis code to the Current Procedural Terminology (CPT) code for the service to determine medical necessity.
Medicare	A nationwide, federally administered health insurance program authorized to cover the cost of hospitalization, medical care, and some related services for the elderly, disabled persons receiving Social Security benefits, and persons with end stage renal disease.
Medicare Choice Plan	A health plan, such as a Health Maintenance Organization (HMO) or Private Fee-for-Service plan, offered by a private company and approved by Medicare. An alternative to the Original Medicare Plan.
Medicare Secondary Payor (MSP)	Centers for Medicare and Medicaid Services (CMS) have identified several circumstances when Medicare will be the secondary payor. The form used to identify the primary payor is commonly known as the MSP.
Medicare Summary Notice (MSN)	Monthly statement listing Medicare claims information. It replaces the Explanation of Your Medicare Part B Benefits (EOMB), the Medicare Benefits Notice (Part A) and benefit denial letters.
Medicare Supplement	An insurance policy that will pay all or part of the patient's responsibility after Medicare pays.

Medigap Insurance	Medigap Insurance is Medicare supplemental insurance. It is private insurance that is designed to help pay Medicare cost-sharing amounts such as Medicare's coinsurance and deductibles, and uncovered services. Medigap Insurance must follow federal and state laws. In most states a Medigap policy must be one of ten standardized polices to help make comparison easy. Patients in Medicare Managed Care plans or whom Medicaid covers do not need Medigap insurance.
Members	Participants in a health plan (subscriber, enrollees, and eligible dependents) that make up the plan's enrollment.
National Association of Insurance Commissioners (NAIC)	An Association of the insurance commissioners of the states and territories. For more information visit their Web site at http://www.naic.org/
National Correct Coding Initiative (CCI)	Established uniform standards for billing with Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) codes. Identifies mutually exclusive codes or those codes that can never be billed together; and identifies potential for fraud and abuse.
Network	An organized group of physicians, hospitals and other healthcare providers working with the health plan to offer quality care at negotiated rates (lower than usual charges) in return for patient flow. Preferred provider organizations (PPO), Prospective Payment System (PPS) plans and Health Maintenance Organization (HMO) plans are all examples of network-based products. Networks are central to managed care.
Newborns' and Mothers' Health Protection Act (NMHPA)	A federal law which mandates that coverage for hospital stays for childbirth generally cannot be less than 48 hours for normal deliveries or 96 hours for cesarean births.
No Balance Billing Provision	A provider contract clause which states that the provider agrees to accept the amount the plan pays for medical services as payment in full and not to bill plan members for additional amounts (except for co-payments, coinsurance and deductibles).
Non-Availability Statement	A statement issued by a uniformed service hospital when medical care is not available at their institution and the patient must use civilian healthcare. Patients who live outside of the designated zip code zone surrounding the service hospital do not need a non-availability statement. This applies for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Patients.
Non-Plan Provider	A health care provider without a contract with an insurer. Similar to a nonparticipating provider under Medicare.
Nurse Practitioner (NP)	A nurse who has 2 or more years of advanced training and has passed a special exam. A nurse practitioner often works with a doctor and can do some of the things a doctor does depending on state laws and provider credentialing.
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.
Occupational Safety and Health Administration (OSHA)	The mission of the Occupational Safety and Health Administration (OSHA) is to save lives, prevent injuries and protect the health of America's workers. To accomplish this, federal and state governments must work in partnership with the more than 100 million working men and women and their six and a half million employers who are covered by the Occupational Safety and Health Act of 1970.
Office of the Inspector General (OIG)	The Office of the Inspector General (Department of Health and Human Services). Centers for Medicare and Medicaid Services' (CMS) enforcement arm whose mandate is to fight waste, fraud, and abuse. Inspectors General are appointed by the agency that monitors compliance in the healthcare industry. It provides policy direction and conducts, supervises, and coordinates all audits, investigations, and other activities designed to promote economy and efficiency or prevent and detect fraud, waste, and abuse.
Omnibus Budget Reconciliation Act (OBRA)	Many federal regulations that impact healthcare financing are the result of budget legislation. Ambulatory Payment Classification's (APC) were mandated by the 1986 OBRA.
Open Access	A self-referral arrangement allowing members to see participating providers for specialty care without a referral form another doctor. Typically, found in an Independent Practice Association (IPA) Health Maintenance Organization (HMO). Also called open panel.
Outlier	One who does not fall within the norm; a term typically used in utilization review. A provider who uses either too many or too few services (for example, anyone whose utilization differs two standard deviations from the mean on a bell curve is termed an "outlier").
Out of Network	Physicians or healthcare delivery systems that are not contracted to provide services covered by a specific health plan.
Out-of-Pocket	The amount the patient/guarantor is responsible for paying for the service received at the hospital can be called out-of-pocket responsibility.
Out-Of-Pocket Maximums	Dollar amounts set by Managed Care Organizations (MCO) that limit the amount a member has to pay out of his or her own pocket for particular health care services during a particular time period.
Outpatient Care	Treatment that is provided to a patient who is able to return home after care without an overnight stay in a hospital or other inpatient facility. An individual who receives healthcare services without being admitted as an inpatient to the hospital.

Outpatient Prospective Payment System (OPPS)	Section 4523 of the Balanced Budget Act of 1997 (BBA) provides authority for CMS to implement a prospective payment system (PPS) under Medicare for hospital outpatient services, certain Part B services furnished to hospital inpatients who have no Part A coverage, and partial hospitalization services furnished by community mental health centers. All services paid under the PPS are classified into groups called Ambulatory Payment Classifications or APCs. Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC for an encounter (taken from CMS website).
Palliative Care	Palliative care is active total care of patients who have advanced illnesses no longer amenable to curative treatment. Control of symptoms, such as pain, is the focus of treatment rather than prolongation of life. Sometimes referred to as comfort care.
Part A (Medicare)	Medicare Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home healthcare. Most individuals over the age of 65 are eligible for Part A coverage. It is free to qualifying individuals, based on employment history.
Part B (Medicare)	Medicare Part B or Medicare supplementary insurance helps pay for doctors' services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Medicare Part A. Part B is supplementary insurance because it is optional coverage for individuals over the age of 65. Participants must pay a premium for Part B coverage. Not all individuals with Medicare Part A coverage are eligible for Part B coverage. Also, many Patients who are eligible for Part A coverage elect not to participate in the Part B option.
Participating Physician	A physician contracting with the payer's managed care program to render services to members as a primary care or specialty care physician or as a consulting physician.
Participating Provider	Any licensed provider of medical or ancillary services contracting with the payer to render services to the payer's insured members.
Patient Bill of Rights	Refers to the Consumer Bill of Rights and Responsibilities, a report prepared by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry in an effort to ensure the security of patient information, promote health care quality, and improve the availability of health care treatment and services. The report lists a number of "rights," subdivided into eight general areas that all healthcare consumers should be guaranteed and describes responsibilities that consumers need to accept for the sake of their own health.
Patient Liability	The dollar amount that an insured individual is legally obligated to pay for services rendered by a provider.
Payer	A health insurance plan or another entity that processes and pays healthcare bills may be called a third party payer, payer, carrier, or insurer. These terms are interchangeable.

Payor	A payor is an individual or company that assumes the risk and is responsible for payment for services. PRIMARY: The initial payor to be billed for services. SECONDARY: Payor who is billed for charges not covered by the Primary payer. TERTIARY: Payor who is billed for charges not covered by the Primary or Secondary Payer
Peer Review	The analysis of a clinician's care by a group of that clinician's professional colleagues. The provider's care is generally compared to applicable standards of care, and the group's analysis is used as a learning tool for the members of the group.
Peer Review Organizations (PROs)	According to the Balanced Budget Act of 1997, organizations or groups of practicing physicians and other health care professionals paid by the federal government to review and evaluate the services provided by other practitioners and to monitor the quality of care given to Medicare patients.
Per Diem	A negotiated daily payment for delivery of hospital services provided; sometimes refers only to “room and board” charges (meals, routine nursing care, etc.), and may or may not include ancillary services.
Physician’s Assistant (PA)	A Physician’s Assistant (PA) is a health care professional licensed, or in the case of those employed by the federal government they are credentialed, to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and write prescriptions. Within the physician-PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. A PA's practice may also include education, research, and administrative services.
Point of Service Plan (POS)	An option offered by a Health Maintenance Organization (HMO) to allow enrollees to use non-HMO providers on occasion. Enrollees select a Primary Care Physician (PCP) and incur little or no out-of-pocket cost. If they use non-participating HMO Providers, there is a higher cost to the enrollee.
Policyholder	Subscriber of an insurance carrier also called insured. The individual who initiates healthcare coverage through an employer, private health plan, or other payer can be called the insured, subscriber, policyholder, or sponsor.
Pre-admission	The process of creating a registration record for a future inpatient service. Commonly known as a “preadmit”. When this process refers to an outpatient, it is commonly known as a pre-registration, although the terms may be used interchangeably.
Pre-Admission Certification	Pre-Admission Certification is the process of assuring that financial prerequisites, such medical necessity, have been met. It does not guarantee payment. The payer usually reserves the right to perform a retrospective review of the medical record to assure that services were appropriate and necessary. This step of the process can be

	time consuming and labor intensive due to the necessity of contacting multiple payers, and coordinating required demographic and medical information. Once approval has been given from the insurance company, a pre-certification number is assigned and given to the healthcare facility.
Pre-existing condition	Medical condition for which diagnosis or treatment was received within a fixed time period prior to enrollment in a group health. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that time period is limited to six months.
Preauthorization	The requirement of most managed care plans to obtain permission from the plan to perform certain outpatient tests or procedures. Once approval has been given from the insurance company, a preauthorization number is assigned and given to the health care facility.
Predetermination	An administrative procedure whereby a health provider submits at treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: patient's eligibility, covered service, amounts payable, application of appropriate deductibles, co-payment factors and maximums. Under some programs, for instance, predetermination by the third party is required when covered charges are expected to exceed a certain amount. Similar processes: pre-authorization, pre-certification, pre-estimate of cost, pretreatment estimate, prior authorization.
Preferred Provider Network (PPN)	A network of physicians and healthcare organizations that provide services to a health plan's members. Providers can join a healthcare plan network by agreeing to provide services to the healthcare plan's beneficiaries for a negotiated rate.
Preferred Provider Organizations (PPO)	Preferred provider organizations (PPO) are a form of managed care health benefit arrangements designed to provide benefits at a reasonable cost by providing its members with incentives to use designated healthcare providers. Also covers care rendered by healthcare providers who are not affiliated with the PPO however, the insured person has a significantly greater out of pocket expense.
Preferred Provider Plan (PPP)	An insurance plan that participates in a preferred provider network.
Premium	Regularly scheduled payment for insurance coverage to Medicare, an insurance company, or a health plan.
Primary Care Network (PCN)	A third-party payer identified as having primary responsibility for payment of charges. A group of primary care physicians who have joined to share the risk of providing care to their patients who are covered under a given health plan.
Primary Care Physician (PCP)	The physician chosen by an insured to coordinate his or her care under a health maintenance organization (HMO) or point of service (POS) plan. Usually, this is the patient’s first contact when receiving

	health care. This is often a family physician, internist, or pediatrician. A primary care physician (PCP) monitors the patient's health, treats most health problems, and refers that patient to a specialist if necessary.
Primary Medical Group (PMG)	A group of physicians in practice together who contract with an insurance company to coordinate a patient's medical care. The group may consist of primary care physicians and specialists.
Primary Payer	Primary payer is the insurer or entity with first priority for payment of a bill.
Prior Authorization	Services that require approval from the insurance company or Primary Care Physician (PCP) prior to the service being performed.
Professional Services	Charges generated for physician services including outpatient office visits and services provided during an inpatient stay. The charges for professional fees are billed separately from the charges for hospital services.
Prospective Payment System (PPS)	Use of a prospective payment system (PPS) means that the payment to the provider is determined in advance and on diagnosis and procedure rather than being retrospectively determined and based on actual charges. In 1983 the Health Care Financing Administration (HCFA) implemented a Prospective Payment System (PPS) for Medicare Part A based on the Diagnosis Related Group (DRG). A fixed payment rate per DRG is set prior to the period during which it applies. Therefore, reimbursement for a patient hospitalization has no direct relationship to the charges or costs incurred in the treatment of the patient. Updates to PPS are published periodically in the Federal Register.
Protected Health Information (PHI)	All medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally, are covered by the final rule. Protected Health Information is a Health Insurance Portability and Accountability Act of 1996 (HIPAA) term.
Provider	A physician, hospital, group practice, skilled nursing facility, pharmacy or any other duly licensed institution or health professional under contract with a health plan to provide professional or health services to members Any entity that supplies medical services is a provider. Hospitals, physicians, pharmacies, and long term care facilities are examples of providers.
Quality Assurance	Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.
Recidivism	The frequency of the same patient being re-admitted to the hospital for the same health condition.

Recurring Visit	A series of visits for the same purpose, such as physical therapy, occupational therapy, radiation therapy, etc. Typically billed on a monthly basis.
Referral	A form (may be electronic) used in managed care plans for the Primary Care Physician's (PCP) authorization for certain specialist and certain services. Some plans may allow physicians other than PCP's to provide referrals.
Referring Physician	Physicians whose care or reference leads to services being provide by a healthcare facility.
Reimbursement	Reimbursement is the amount of cash paid to the hospital by Patients and third party payers for healthcare services.
Rejection, Claim	A refusal by a third-party payor to pay or consider a claim.
Rejection, Computer	An electronic transaction that fails to update a system – i.e. an Admission Transfer Discharge transaction (ADT) or registration that it not accepted by an ancillary system.
Relative Value Scale	A list of procedure codes that uses units to indicate the relative value of medical services performed by physicians. This coding system is used in many states for billing worker's compensation claims.
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.
Revenue Code	Codes established by the Health Care Financing Administration (HCFA) submitted on HCFA standard forms to identify hospital and ancillary services. Revenue can be defined as the charges generated as patients are given care. Codes submitted on the Uniform Billing Code (UB-04) to identify an inpatient accommodation code or and ancillary charge.
Revenue Cycle	All administrative and clinical functions that contribute to the capture and presentation of patient services for payment.
Risk (contract)	A contractual agreement where all healthcare services are provided for a fixed monthly payment for all members enrolled. The providers are at financial risk for all services that are provided.
Routine	A standard set of procedures or activities.
Secondary Insurance Care	A second third-party insurance plan to cover expenses not paid by the primary payor. Services provided by medical specialists, such as cardiologists, urologists, etc. Generally, they are not the patient's first contact.
Secondary Payer	Secondary payer is the insurer or entity with second priority for payment of a bill, after the primary payer.
Self-Administered Drugs (SAD)	Self-administered drugs (SAD) are oral or topical medications identified by Medicare as drugs that can be administered by the Patient in an outpatient setting and are not payable by Medicare. Examples are aspirin or an antibiotic ointment.

Self-Funded Plan	Managed Care Organization (MCO) or insurance company, is financially responsible for paying plan expenses, including claims made by group plan members. Also known as a self-insured plan.
Self-Pay	That portion of the bill that is to be paid in part or in full by the responsible party from their own resources, as it is not payable by a third party.
Share of Cost (SOC)	The amount a patient covered by Medicaid must pay for eligible medical expenses out of his or her pocket. The amount varies according to the patient's current maintenance or financial status. Verification through the Medicaid system is required for each patient visit. Medicaid cannot be billed until the patient's share of cost is satisfied.
Skilled Nursing Facility (SNF)	A facility which primarily provides inpatient skilled nursing services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
Sponsor	The individual who initiates healthcare coverage through an employer, private health plan, or other payer can be called the insured, subscriber, policyholder, or sponsor.
Standard of Care	A diagnostic and treatment process that a clinician should follow for a certain type of patient, illness, or clinical circumstance.
State Children's Health Insurance Program (SCHIP)	A program for uninsured children in the United States that is administered by Centers for Medicare and Medicaid Services (CMS) in conjunction with the Health Resources and Services Administration.
State Health Insurance Assistance Program (SHIP)	A State organization that receives money from the Federal Government to give free health insurance counseling and assistance to Medicare beneficiaries.
Stop-loss Provision	A form of contracted payment that allows for a higher claim payment for a qualifying catastrophic hospitalization. For example, a hospital may have a stop loss provision in its contract with the insurance company for accounts that exceed $100,000.00. After an account hits $100,000.00, the hospital may receive 80% of its charges in lieu of the negotiated per diem or case rate payment.
Subscriber	The individual who carries the insurance initiates healthcare coverage, through an employer, private health plan, or other payer can be called the insured, subscriber, or policyholder. Also referred to as the insured, or sponsor.
Supplemental Policy	Secondary insurance is designed to decrease the patient obligation after primary insurance has been processed.
Tertiary Care	The third level of care provided to patients requiring the most complex and sophisticated medical techniques and technologies (e.g., organ transplants, neonatal specialties, etc.)
Tertiary Payer	Tertiary payer designation is the insurer or entity with third priority for payment of a bill, after the primary and secondary payers.
Third Party	An organization that administers health insurance plans or claims

Administrator (TPA)	but does not assume the risk.
Third Party Payer	A health insurance plan or another entity that processes and pays healthcare bills may be called a third party payer, payer, carrier, or insurer. These terms are interchangeable. The patient is considered the first party, the provider of services is considered the second party and the insurance carrier paying for the services rendered is the third party.
Tracking Number	A number given by the insurance company or a third party payer as confirmation of receiving a notification of a patient's admission or surgery. It does not serve as authorization of services. In addition, they require the review organization to be notified for an authorization number.
Transaction	A transaction is a data exchange of information.
Tricare	Tricare is the Department of Defense's health care program for members of the uniformed services, their families and survivors.
UB-92	Uniform bill 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. This was replaced by the UB-04 in 2007.
Uniform Billing Code (UB04)	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.
Unique Physician Identification Number (UPIN)	Required for Medicare and Medicaid billing. A physician or supplier that bills Medicare for a service or item must show the name and the Unique Physician Identification Number (UPIN) of the ordering/referring physician on the claim form. The Health Care Financing Administration (HCFA) application 855 must be filled out in order to receive a UPIN number.
Urgent Care (UC)	Urgently needed medical attention that may be provided in a setting other than an emergency department.
Usual, Customary and Reasonable (UCR)	The amount a health plan will recognize for payment for a particular medical procedure. It is typically based on the average or prevailing fees for a specific service within a given geographical area. It is what is considered "reasonable" for that procedure in the patient's service area.
Utilization Management (UM)	The monitoring and controlling of healthcare services provided to a particular patient population to assure cost effective, quality care.
Waiver	An amendment to a health insurance policy that excludes coverage for a specific condition. An agreement to give up a legal right.
Window	A rectangular area shown on a computer screen to display data including drop down menus.
Workers' Compensation	Services where benefits are in whole or in part either payable or required to be provided under Workers' Compensation or Occupational Disease law. California has a no fault system whereby the employer covers the worker's injury and in return the employee does not sue the employer.

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