

FEATURE

Improving Registration Accuracy

By Paul Shorrosh

As a newly-installed business office director at a 250-bed hospital with decentralized registration, I was astounded by the number of complaints I got each week from billing, collections, HIM and even IT departments, all pointing to data quality errors made during patient registration. It was, without a doubt, the number one internal complaint of the business office, which included patient financial services (PFS), billing, collections and patient access departments.

After years of brow-beating, the complaints had desensitized my access employees, so my first inclination was to protect them. But at the same time, they needed to improve their accuracy rate for billing. I needed a way to monitor and track accuracy, and somehow bridge the divide between front and back. Soon I began to envision a way for patient access employees to self-correct and learn from their mistakes.

I started by analyzing the complaints and ranking them by frequency and impact. I studied remit denials, billing system reports and interviewed billing staff to identify the top five registration errors, then the top 10, until I understood what was going on. The errors fell into three categories: financial, operational and

compliance. Financial errors would stop or deny the claim, such as missing guarantor or subscriber information, invalid policy or group numbers, or missing authorizations. Accident claims with missing occurrence codes were problematic, as were incomplete workers' compensation claims, secondary plans that were loaded as primary, and many others.

Operational errors cost us in terms of rework and returned mail due to incomplete names or addresses, invalid phone numbers, invalid punctuation and mismatched data elements, such as financial class and stay type, or certain admit codes that required a corresponding service code. Compliance errors included patient safety issues, such as duplicate medical record numbers, as well as legal risks, such as minor guarantors, privacy notice errors, incomplete ER logs and incomplete Medicare Secondary Payer Questionnaires. The more I looked, the longer my list became. Some errors seemed simple and even petty, such as middle initials instead of names, but they caused confusion in choosing from the Master Patient Index and often resulted in duplicate medical records—a serious patient safety issue. Every error in patient access cost us dearly in legal risks, downstream rework and of course, payer denials.

In researching the problem further, I discovered that 70 percent of data elements required to bill a UB92¹ claim come from patient access. I learned that registration error rates averaged 30 percent nationally², and were probably higher if the study had encountered the variety of error complaints I was seeing. Studies estimated that as much as 80 percent of billing office staff time was dedicated to rework³. And what really caught my attention, were estimates that 50 percent to 90 percent of claim denials could be prevented by securing accurate patient information at the front door^{4,5}. Could it be that the “lowly” patient access employee could be the most valuable player in the revenue cycle?

Like most of my counterparts, I understood fully the “garbage in, garbage out” theory. But every article I read and every workshop I attended recommended some form of manual quality review as the only solution. But we were already doing that, and doing it well. So well, in fact, that my patient access supervisors were spending three to four hours each day doing manual review and error reporting. With 350 average registrations per day, they only had time to review about 30 percent of our accounts. Their primary tool was a static list of registrations from our patient accounting system, basically the hunt-and-peck method of identifying errors. They also reviewed the billing department's marked-up face sheets and corrected errors so the claim could drop, or in some cases re-bill. Then they keyed errors into spreadsheets in an attempt to organize the information and report it to each employee once a month. It was a valiant

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but ineffective effort, and a poor use of valuable time and talent. No matter how well it was done, the error rate did not drop, and neither did complaints, rework or denials. We needed automation.

Back-end software tools for billing purposes were plentiful, but after a fruitless search for front-end solutions, I went to my patient accounting system vendor. After all, it was their registration system that allowed the errors to occur. But their response was basically, “Problem—what problem?” They were not interested in developing a system solution for what they considered to be strictly a management problem. Their recommendation was simply to “make the employees do it right.” This of course, from well-meaning folks who had never registered a patient or managed a patient access department.

But in their defense, it is hard to appreciate the complexity of patient registration if you’ve never actually done it. It looks like simple data entry. But look a little closer. In the last five years I would estimate that the duties and complexity of the typical registration job have doubled. Ten years ago, it was more like basic data entry with a smile. Now, aside from the 12 to 15 software applications and Web sites that my staff had to master (compared to four for the typical billing office employee), access employees typically are required to understand Medicare, Medicaid, Managed Care, and private insurance plans and regulations. Today, they verify insurance and address information, eligibility, physician orders, check for medical necessity, verify benefits, co-pays and deductibles, interpret insurance coverage, price procedures, review prior balances and even conduct basic financial counseling. Then there is the challenge of collecting co-pays and deductibles from sick patients at the point of service, requiring a finesse and style that only

comes naturally to some, and requires scripting for most. Some access employees also have the added duties of scheduling, pre-registration, bed placement, and even early posting of procedures and charges. Oh, and that doesn’t even include the data-entry portion of the actual registration. Dare I mention the ever-looming requirements of HIPAA privacy and security, Patient Rights, EMTALA and Fair Debt regulations and JCAHO requirements? It’s no wonder that training and certification programs like the CHAA have become so important.

All of these job challenges are compounded by a constantly changing environment, an industry shift to decentralized registration models, the need to provide first-impression-level customer service and the need for speed. Let’s face it, when you have 10 patients waiting to be registered, accuracy is sacrificed for speed, service and collections. But accuracy is what gets you paid. What a dilemma for patient access managers and employees!

We polled counterparts at other hospitals who also were reviewing random accounts manually. The best programs had full-time staff dedicated to manual quality review, but even those programs were limited to random accounts, reviewer subjectivity and inconsistencies. Were they reviewing for 10 types of errors or 50? How complete were the reports they used to conduct reviews? And, after finding errors, how do they record the information for statistical and training purposes? It was an information management problem begging for a solution, and it became apparent at my hospital that if I needed the solution, I would have to develop it.

After months of testing, we finally developed a model which automatically identified 15 common registration errors and reported them back to each patient

access employee for self-correction. It was easy to use, and the initial results were worth celebrating with a pizza party. Now that we could track error rates with relative ease, we watched them drop from 35 percent to 10 percent in the first six months. That year, we hit the lowest A/R days in five years, and denials dropped by 20 percent. Clean claim rates were higher, and complaints from the PFS and HIM departments trickled to almost nothing. My patient access manager and supervisors recovered three to four hours per day to manage processes and train employees more effectively. Patient access employees appreciated being able to learn about and correct their own errors before anyone downstream had a chance to complain. Soon our patient access staff began competing to see who could have the lowest error rate in the department.

Having recently returned to full-time consulting, I received numerous client requests for help with registration accuracy. After redesigning a program for commercial use and protecting it with copyrights and patent pending, it only took six months for 12 hospitals to adopt AccuReg™, software for registration accuracy, and interest is still growing. And about my old hospital... they tell me the error rate is now down to 5 percent. But even better than a 5 percent error rate is the knowledge that those few errors are being corrected by patient access employees before they get to coding or billing. That alone was worth it all.

¹ National Uniform Billing Committee—UB-92 (Form HCFA-1450)

² Zimmerman & Associates Revenue Cycle Journal, Feb/2004

³ Health Information Technology Magazine, Aug/2003

⁴ Pesce, J., “Stanching Hospitals’ Financial Hemorrhage with Information Technology.” *Health Management Technology*, Aug/2003

⁵ Atchison, K. *Healthcare Financial Management*, May/2003