4 MYTHS OBSTRUCTING A PATIENT FRIENDLY FISCAL EXPERIENCE

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RELEVANT EXPERIENCE…

Professionally:

PARRISHSHAW

Beaufort Memorial HOSPITAL

Davis HealthSystem

In Real Life:

PATIENT FRIENDLY FISCAL EXPERIENCE

A Case Study

THE SCENARIO

Accidents happen right?

- 4pm on a Friday last February
- First step is a doozy
- Mom, happens to be in town

- Health insurance
  - Employer sponsored health plan

- After school care provider
  - Accident insurance

CLOSED COMPOUND FRACTURE

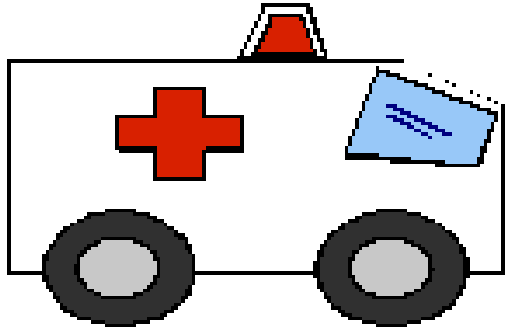
RADIUS AND ULNA

40 minutes until transport arrived

Husband arrived just as we were loading

Paperwork, an accident form from the aftercare provider, handed to EMS

EMS also reviewed Health Insurance Card



DEMOGRAPHIC VALIDATION IS DONE AT THE REGISTRATION DESK OR BEDSIDE FOR EVERY PATIENT.

Myth #1

CASE STUDY NOTES

Quick registration information of name, date of birth and allergies taken by nurse (new patient)

Radiographs taken

Insurance and Accident Form exchanged

Registrar visited for consent signature

Addie Jo stabilized…

Injury too complex

Transfer necessary

Second ambulance (different provider)

Second facility with Pediatric Orthopedics

Additional rounds of films

Key difference at second facility:

Registrar approached the bay empathetically and talked us through a validation process

Demographic errors discovered

THE MYTH VERSUS REALITY

Myth:	**Reality:**
All demographics are captured.	Ambulance Bay = Risk
Consents are explained to and read by guarantors.	Consents are signed hastily, explanations consist of the following, ‘Please sign here giving us permission to treat you/your loved one.’
Insurance information is provided, quick registration is properly used.	May be provided, validation may or may not occur.

IDEAS TO COMBAT FAILURES

Technology is only as good as the procedures pertaining to its use
- Address used in our instance was an associated address

High risk patient scenarios require a higher level of resources
- What are the follow up means used?
- Clinical areas understand this leads to better outcomes

Closer scrutiny regarding ‘checkout’ practices
- True validation opportunity critical

Closing gaps and ability to bypass the system
- Applicable to both patients and employees

PATIENTS ARE INFORMED REGARDING ‘BLIND SERVICES.’

Myth #2

CASE STUDY NOTES

Oft times facilities are not all inclusive owners of all services needed

Radiologists, anesthesiologists/CRNAs, pathologists, hospitalists and emergency physician groups

Consents and statements include a disclaimer

‘Blind providers’ may or may not be considered in-network

Addie Jo needs surgery…

Bedside manipulation failed

Surgical intervention was successful

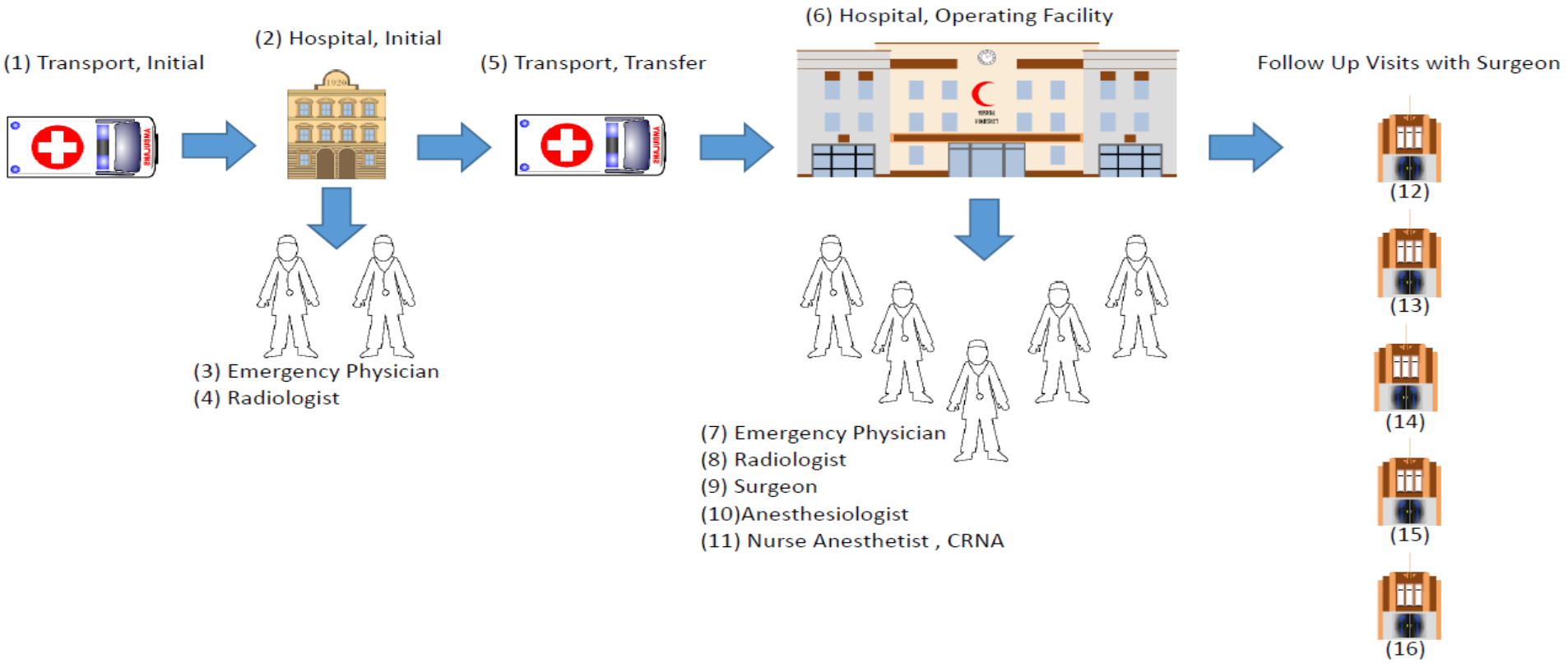
We added several providers to the growing list

Attempt at correction:

All primary facilities and transporters contacted first business day after injury. Assured all blind providers received accurate demographic.

SO HOW MANY PROVIDERS USED/CLAIMS CREATED FOR A SINGLE ACCIDENT?

Graph 1.1: Illustrates the number of claims () generated from a singular accident without consideration of incorrect billings, denials or appeals



THE MYTH VERSUS REALITY

Myth:

‘Blind provider’ is explained in the consent.

Guarantors are solely responsible for knowing network status.

‘Blind providers’ receive accurate/current information regarding patients.

Reality:

Flawed consent process.

Network status is rarely understood. The facility network status is sometimes understood (RAP).

Failures in validation may or may not occur. Updates to guarantor and patient info may or may not flow.

IDEAS TO COMBAT FAILURES

Creative contracting

- All providers on board
- Agreed upon policies and procedures for patient relations

True consumer advocacy

- In total or case by case

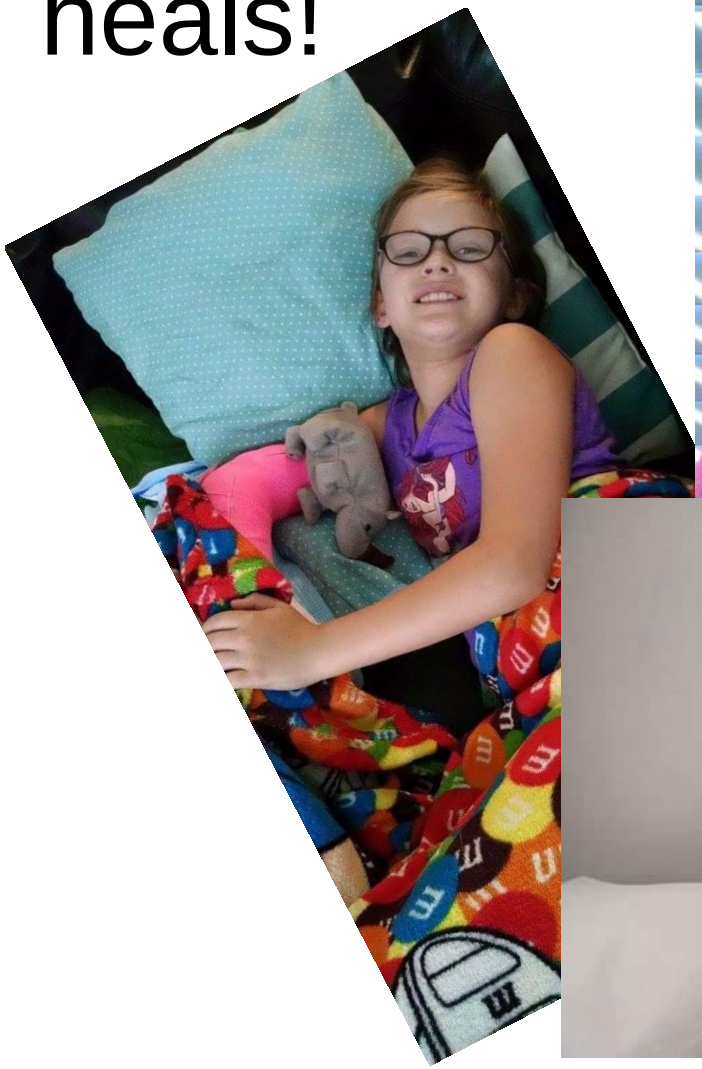
Focused, proactive approach to helping patients to navigate

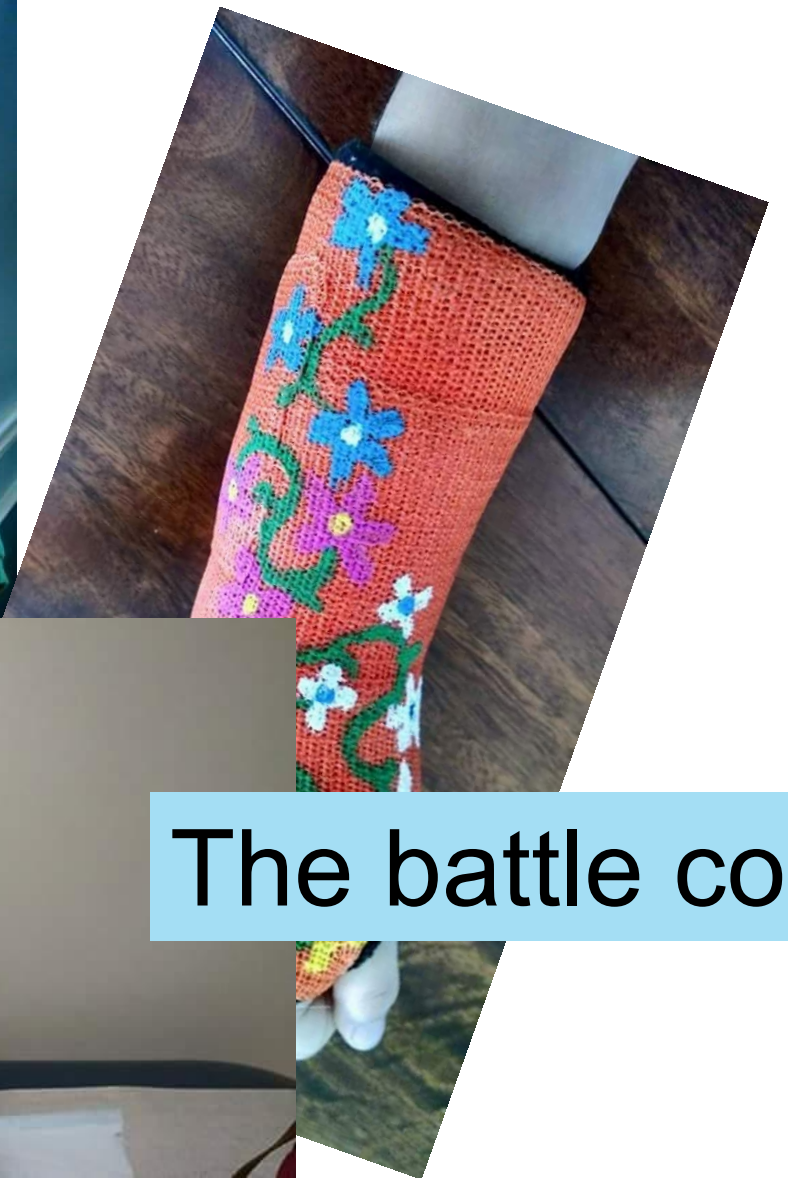
- All staff trained and given the tools for success

NO FACE SHEETS!

- Push for real time automation of data exchange
- Updates and corrections must flow as well

The arm heals!





The battle continues…

INSURANCE VERIFICATION AND COORDINATION OF BENEFITS (COB) IS COMPLETED AT MULTIPLE POINTS IN THE REVENUE CYCLE.

Myth #3

CASE STUDY NOTES

COB (Coordination of Benefits) can change

COB is not one size fits all, highly dependent on circumstance

COB can be a ‘Jenga’ piece

Foundation block for Fair Credit Reporting Act (FCRA) compliance

Addie Jo recuperates…

Explanations of benefits begin to pour in

Surgical follow ups begin

COB spelled out on accident form

Coupled with demographic errors, $ left on table with patient holding the bag

Search and conquer:

Weekly, sometimes daily follow up was required. One anesthesia provider tracked down through the NPI registry based on an incorrect claim filing.

THE MYTH VERSUS REALI

Myth:

COB is static.

Liability insurance is primary.

Patients are responsible for relaying proper primary and secondary coverage.

Reality:

Until reimbursement, COB can change.

While usually the case, this ordering is circumstance specific.

Facilities must protect the operating margin and be compliant with FCRA.

IDEAS TO COMBAT FAILURES

Hot button legislative topic

Federal Reserve researchers found that **over half of collection agency accounts and nearly one-fifth of lawsuits that show up as negative items on credit reports are for medical debts.**

Facilities are extremely adept at assigning COB pre-service for scheduled services

Similar strategies during the encounter and post service must be implemented

Training is paramount

Engaged staff

PATIENTS, NOT STAFF, ARE ULTIMATELY RESPONSIBLE FOR UNDERSTANDING COVERAGE/PLAN/SERVICES/ETC.

Myth #4

CASE STUDY NOTES

Silo functionality produces subpar results/underpayment

Variance removal within financial areas is just as important as the clinical setting

All staff must comprehend and be engaged

Mom understands the benefits/coverage/etc…

The guarantor does not control the process

Relentless follow up

Traditional interactions with patients perpetuate mediocrity

THE MYTH VERSUS REA

Myth:	**Reality:**
Staff have a comprehensive understanding of process and implications of errors.	Disengagement and training gaps exist.
Patients are willing participants in care.	Most patients are engaged. However, the environment is convoluted and difficult to navigate.
Patients are financially responsible for care if insurance does not pay.	Inaccurate claim filings cost facilities reimbursement, resources, and reputation.

IDEAS TO COMBAT FAILURES

True patient financial advocacy

- No longer just counselling on ways to pay a single bill

More than warm bodies

- Right person, right fit
- Invest in staff

Creative resources

- Web tools
- Community event presence

ANY GUESSES ON DAYS TO RESOLUTION?

5 months and 23 days

Feb 28-Aug 23

176 days

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Question?