

# REGISTRATION ALERT

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## For those who do Registration

### *Salutations and Commendations!*

A big tip of the hat goes to the following registrars who have maintained a consistently high accuracy rate for the previous month! Be sure to give these fellow employees a round of applause, especially if they work in your area!

Ruthie Lewis- Admissions  
Matt Michalski- Admissions  
Donnell Montgomery- Admissions  
Shantell Nelson- Admissions  
Charlotte Smith- Admissions  
Kim Tyler- Admissions  
Carolyn Tidwell- CWC  
Jacqueline Carter- CWC  
Loria Williams- CWC  
Rosie Shelton- CWC  
Toshia Hogan- Family and Preventative Medicine  
LaTasha Jones- Center on Aging  
Linda Gray- Rehab COA  
Tressia Roberts- Rehab COA  
Lisa Sims- ACRC 6

We also want to recognize those who have made tremendous improvement in the past month. Great job! Keep up the good work!

Anita Carlton- BONC  
Crystal Gardner- BONC  
Troy Sunkins- RAD  
Veronica Guydon- UWHC  
Lisa Montgomery- UWHC  
Emily Thomas- Surgery  
Gale White-Moore- MRI/CT

## ACCOUNTS CORRECTIONS!

### *Revenue Integrity Specialist Team*

In the past we have asked that registrars e-mail "PBS accounts corrections" with any corrections that are made to UAMS patient accounts. With the advent of First Class, the "PBS" e-mail address is no longer available. Until a more permanent arrangement can be made we have been asked to let you know that you can e-mail those accounts corrections to Nelda Ashby or Lisa Coleman. They may be found in the First Class directory (or global addressbook if you are still on Outlook).

Stay tuned for updates!



## BCBS: SIMPLIFIED!

The BCBS plan codes have been simplified by discontinuing the use of B25- BCBS Out of State. If you encounter a BCBS out of state, regardless of what the card says, please use the B02:OAP plan code. We ask that you do not change the default claims address, however- in the *Address 2* line of the claims address please input the state that the policy originates from.

Attached to this Registration Alert you will find an updated copy of the BCBS Plan Code Table. Also included is an updated version of our handy desk top reference. Please print this out and slide it into a plastic page protector and keep handy on your desk. It includes the BCBS plan code table as well as those for United Healthcare, Qualchoice, Cigna and some of the more commonly used commercial codes.


*For those of you on First Class, the Registration Alert will now be available through a conference. "Admission Regist Newsletter Con" will automatically show on your FC desktop. E-mail me- Kylie Corriveau, if you have first class and do not have this- I'll set you up! Check out the Registration Alert on our website too, at [www.uams.edu/rist/](http://www.uams.edu/rist/)*



## S.T.A.R.

*Striving Together, Achieving Results*

I am happy to announce that the STAR for the month of August is none other than Debra Reed of the UPMG Clinic. Debra has been working in UAMS since 1998. She joined the staff at UPMG Clinic in 1999 as a Registration and Appointment Specialist. Currently, she holds the position of Point of Service Coordinator for UPMG, a promotion she earned in 2001.

Besides being what Anita Griffin the Clinical Director of UPMG describes as, "...a valuable  member of the UPMG Team..." Debra is also busy outside of work as she pursues a degree at the UALR for Health Sciences. Debra hopes to use this degree to be a certified Health Educator. In addition to all this, Debra is also a dedicated wife, mother and grandmother! She's able to juggle all these roles with what her co-worker Justin Phillips calls "grace and class."

Congratulations, Debra Reed for what your peers all agree is a well-deserved recognition of being chosen as this month's STAR.

\*\*You can find a copy of the nomination form at <http://www.uams.edu/rist/>

# OUT OF STATE PATIENTS: Self -Pay and Medicaid

Sandy Ledbetter

UAMS accepts some out of state Medicaid insurance, but the eligibility cannot be checked by normal means. Similarly, UAMS accepts self pay patients from other states, even from out of the country, but those patients are not be eligible for the kind of aid that we are able to offer to Arkansas residents. Before we can provide care to an out of state Medicaid or self-pay patient follow the instructions below.

## International Non-Citizen Self-Pay:

### **No insurance- non-emergent patients-**

- Must pay in advance for treatment – for either an in or out of state international non-citizen patient.
- The Hospital Discount does not apply for these patients.
- We do **not** set up payment plans for international patients.
- Patients can have an appointment in one of the clinics, but they must pay prior to the date of the appointment.
- Refer to Sandy Ledbetter (686-8071) if they need surgery or further testing. Sandy will need to estimate the cost and arrange payment, talk to patient, etc.

## Out of State Patients- Self-Pay and Medicaid:

- UAMS does not accept all out of state Medicaid - refer to Sandy- we may take them, but she will verify **prior** to them being given an appointment.
- In some **very rare** cases, UAMS may take surgical non-covered patients. Check with referring physicians to see what type of surgery is indicated and then go through Sandy to explain the policy.
- Sandy will help patients that we cannot see to find a suitable substitute in their own state
- The physician may file an appeal on behalf of the patient who is turned down for treatment
- UAMS does not take Medicaid from certain border states so **always** refer to Sandy.

Ask patients if they are a US Citizen and ask for a Social Security Card. Staff needs to be careful how this information is presented. Generally, ask if they are a resident of Arkansas and if they are a US citizen, then ask for their social security number.

## Info Release Indicator Field

*Anita Westbrook*

The Info Release Indicator field in HBOC/OSCAR is used to indicate that a patient has “opted out” of all or part of the patient directory. We sometimes refer to these patients informally as “no info” patients. This field is visit specific and is usually **empty**. The **only** time an entry should be made there is if the patient asks to be excluded from the directory, or if UAMS elects to exclude a patient, for example for safety reasons. In those instances a “Request to be Excluded from the Patient Directory” form must be filled out and scanned into EPF. An entry in the Info Release Indicator field prevents those patients from showing on the Patient Information Screen in OSCAR and the INFO (Information Desk Inquiry) screen in HBOC which are used to help visitors locate patients in our facilities. For additional information and to see the detailed Patient Directory workflow, go to <http://www.uams.edu/rist/training.asp> or <http://hipaa.uams.edu/empworkflow.htm>.

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# The COB'ing CONUNDRUM!

How accurately a patient's insurances are COB'd will affect the billing process. For example, if a secondary insurance is billed first, they will deny the claim and request that it is billed to the correct primary insurance before they will pay their portion. This can delay the payment weeks, even months, tying up money that should be going to good use here at our hospital!

Medical College Physicians Group recently shared some information about the number of denied claims we get back from insurance companies for this specific type of error. So far this year alone there have been 8605 claims denied because of COB errors. That's over 1200 per month! We were able to break that number down - which will help us find out where our registration weaknesses are.

The reports show that 6109 of those errors are on Medicare accounts. That's a whopping 72%. BCBS errors come to 994, which is almost 12%, and Medicaid comes in with a tiny 2% (202 errors). The remaining 14% are errors made on other assorted insurances, including commercial and managed care plans. This information clearly shows that we need to give a little more attention to Medicare accounts and how we COB them. In addition to holding up our revenue cycle, Medicare is very conscious about the MSP questionnaire- which helps determine if Medicare is primary or not. Filling out the MSPQ incorrectly could be construed as fraudulent as well- so interviewing your patients is essential.

Some things to consider when registering:

- Verbally go through the MSPQ with the patient.
- Be wary of accounts that are "copied forward". You never know if the last registrar had it right!!!
- Review the "plan codes and COB" section in the Strengthening Bridges Manual (available at our website if you have not been to class yet!)

Coordination of Benefits is covered briefly in our Role in Access class, but is outlined in more detail in our Strengthening Bridges class. More specific information and practice activities are available in the manuals and from any of the Revenue Integrity Specialist Team members. For now, try your hand at these (mark each one 1, 2, etc...to show COB order):

- A. \_\_\_\_ Medi-Pak \_\_\_\_ Medicare A \_\_\_\_ Medicare B  
B. \_\_\_\_ Medicare A \_\_\_\_ Medicaid \_\_\_\_ Medicare B \_\_\_\_ AARP Supplement  
C. \_\_\_\_ MCPG Fringe \_\_\_\_ QualChoice (spouse's insurance)  
D. \_\_\_\_ Medicaid \_\_\_\_ MCPG Fringe

Don't cheat! Check your answers to the right!!

Answers:  
A. 3, 1, 2  
B. 1, 4, 2, 3  
C. 2, 1  
D. 1, 2

## The Medicare Secondary Payer Questionnaire (MSPQ)

The provider is required by federal regulations to properly determine whether Medicare should be billed as the primary or secondary payer. This is done by using the **Medicare Secondary Payer Questionnaire (MSPQ)**. The MSPQ is a series of questions that lead the provider to the determination of which insurance is primary. It must be completed regularly according to federal law. Failure to complete it honestly and accurately may result in federal penalties that include fines and/or imprisonment, if the action is deemed to be abusive or fraudulent. The fines range from \$5000-\$10,000 per line item on a claim. In addition to fines and/or imprisonment, the provider may lose the privilege to treat and bill for Medicare beneficiaries.

**Medicare is usually secondary to:**

- Auto or other liability insurance
- Agencies, Grants and Studies
- Employer group plan with over 100 employees when the Medicare entitlement is Disability
- Veterans Administration coverage
- Black Lung benefits
- Employer group plan with over 20 employees, when the Medicare entitlement is Age
- Any payer for ESRD patients who are within their 30 month coordination period

**Please see the attached table for help on answering each of the questions on the MSPQ!**