11-10
Memorial Health System
Patient Access Audit

May 2011
Purpose
The purpose of this audit was to determine the accuracy of patient admissions data as it relates to timely availability of information for billing and to assess compliance with departmental policies and procedures for registering patients.

Highlights
We conclude that overall, patient registration data was accurate and reliable. We also found departmental policies and procedures were generally followed. However, during the course of our audit, we identified areas where we believe internal controls could be strengthened and processes could be improved.

Our audit period covered the three months ended March 31, 2010. During this period, a total of 134,027 patients were registered, including 125,570 outpatient registrations and 8,457 inpatient admissions. Patient Access was the department responsible for registering patients throughout the health system, with the exception of certain offsite locations where registrations were handled by staff members who reported to managers outside of Patient Access. All staff members who register patients are referred to as Registrars.

The registration process involved the collection and documentation of demographic, insurance, and physician information as well as transferring information related to the patient’s procedure and diagnosis from the physician’s order to the patient’s Memorial account record.

The focus of our audit was to review the accuracy of information captured by the Registrars and to determine whether department policies and procedures were being followed. This included testing a sample of patient registrations during the audit period to verify certain information.

(Continued on page 2)

Management Response
Management was in general agreement with our audit comments. The complete responses can be found in the body of the detailed report.

Recommendations
1. Patient Access should strengthen the process of detecting registration errors on the front-end.
2. Patient Access should enforce policies and procedures related to copayment and pre-deposit collections in the Emergency Department.
3. Patient Access should identify ways to reduce the creation of duplicate patient medical records.
4. A strategy should be implemented to reduce the number of errors at offsite registration locations staffed by non-Patient Access personnel.
5. Registrar accuracy should be evaluated against a performance standard.

See the findings and recommendations section of this report for more details.
documented during the registration process.

During our testing, we noted some errors related to inaccurate collection of patient demographic or insurance information and other instances when Patient Access policies and procedures were not followed. Types of errors varied and included availability of registration documents, co-payment procedures, duplicate medical records as well as data input errors. These errors did not appear to impact patient care, but could have impacted billing in some cases. Of all the test work we performed to verify the accuracy of registration data, the registration areas staffed by non-Patient Access personnel had the highest concentration of errors.

We also noted room for improvement in performance monitoring activities for Registrars. While Patient Access managers received error information periodically, there was no formal process in place for accountability tracking past an initial 90-day review period for new hires. This left performance monitoring to the discretion of individual managers.

We recognize Patient Access management was working on several efforts to improve processes and controls at the time of our fieldwork. These efforts included increasing the number and scope of manual quality assurance reviews performed internally for a sample of patient registrations and researching an audit tool to assure accuracy of critical fields which impact billing. We noted increasing detection of registration errors will provide the necessary information for determining accuracy rates of individual Registrars and will allow these results to be compared to an established accuracy standard.
Date: May 20, 2011

To: Honorable Mayor and Members of City Council  
Members of Memorial Health System’s Audit Committee  
Members of Memorial Health System’s Board of Trustees

Re: 11-10 Memorial Health System Patient Access Audit

We performed an audit of the Memorial Health System (Memorial) patient registration process. The audit period covered the three months ended March 31, 2010.

The purpose of this audit was to determine the accuracy of patient admissions data as it relates to timely availability of information for billing and to assess compliance with departmental policies and procedures for registering patients. The audit also examined controls over payments received by Patient Access personnel. Patient Access was the department responsible for registering patients throughout the health system, with a few exceptions.

We conclude that overall patient registration data was accurate and reliable. We also found departmental policies and procedures were generally being followed. However, during the course of our audit, we identified areas where we believe internal controls could be strengthened and processes could be improved. These are listed on the pages that follow.

As always, feel free to contact me if you have any questions.

Sincerely,

Denny Nester  
Interim City Auditor  
MBA, CPA, CIA, CGFM, CFE, CGAP

Cc: Dr. Larry McEvoy II, Chief Executive Officer  
Mike Scialdone, Chief Financial Officer  
Tracy Narvet, Controller  
Cindi DeBoer, Associate Administrator of Patient Finance  
Lori Harrison, Director of Patient Access  
John Wyckoff, Compliance Officer
Observation 1 – Patient Access did not have an adequate process in place on the front end to identify errors in the registration process and correct them in a timely manner.

Observation 2 – Patient Access copayment and pre-deposit collection procedures were not always followed in the Emergency Department.

Observation 3 – Patient Access processes were not effective in preventing the creation of duplicate patient medical records.

Observation 4 – Having non-Patient Access staff responsible for patient registrations at certain offsite locations increased the occurrence of errors and non-compliance with departmental policies and procedures.

Opportunity 1 – Performance monitoring activities for registrars could be improved.
REPORT DETAILS

PURPOSE AND SCOPE

The purpose of this audit was to determine the accuracy of patient admissions data as it relates to timely availability of information for billing and to assess compliance with departmental policies and procedures for registering patients. The audit also examined controls over payments received by Patient Access personnel. The audit period covered the three months ended March 31, 2010.

The Patient Access Benefit Coordinators played a role in counseling patients on various assistance programs and in some cases, assisted with the application process for these programs. While we recognize the importance of the patient financial counseling function and Patient Access’ role in this process, we considered it to be outside of the scope of this audit and it was not reviewed. In addition, user access to the Hospital Information System for registering patients was not reviewed as a part of this audit.

BACKGROUND

The Patient Access Department was responsible for registering patients throughout the health system, with the exception of certain offsite locations where registrations were handled by staff members who performed registrations as well as other job responsibilities and reported to managers outside of the Patient Access Department. All staff members who register patients are referred to as Registrars.

The registration process involved the collection and documentation of all demographic, insurance, and physician information as well as transferring information related to the patient’s procedure and diagnosis from the physician’s order to the patient’s Memorial account record. Patient Access was also responsible for completing the following tasks as part of the registration process:

- Obtaining a copy of the patient’s insurance card
- Verifying insurance eligibility
- Obtaining insurance authorizations in certain circumstances
- Collecting copayments (as required by the patient’s insurance) and pre-deposits (for self-pay patients)
- Providing various required disclosures and obtaining a signature acknowledgement from the patient
- Contacting inpatients to discuss benefits, out-of-pocket responsibility and payment options

Registrars were expected to perform the above mentioned responsibilities in an accurate, timely, and confidential manner, while providing optimal customer service to patients.
During the audit period of January through March 2010, there were a total of 134,027 patients registered throughout the health system. This included 125,570 outpatient registrations and 8,457 inpatient admissions.

This is the first review of Memorial’s patient registration process conducted by the City of Colorado Springs, Office of the City Auditor (OCA).

CONCLUSION

We conclude that overall, patient registration data was accurate and reliable. We also found departmental policies and procedures were generally followed. However, during the course of our audit, we identified areas where we believe internal controls could be strengthened and processes could be improved.
OBSERVATIONS, RECOMMENDATIONS AND RESPONSES

OBSERVATION 1 – PATIENT ACCESS DID NOT HAVE AN ADEQUATE PROCESS IN PLACE ON THE FRONT END TO IDENTIFY ERRORS IN THE REGISTRATION PROCESS AND CORRECT THEM IN A TIMELY MANNER.

Of the 72 patient registrations we reviewed during the audit period, there were 13 errors related to inaccurate collection of patient demographic or insurance information and 30 instances when Patient Access policies and procedures were not followed. Types of errors varied and included availability of registration documents as well as data input errors. These errors did not appear to impact patient care.

According to the June 2009 Healthcare Financial Management Association (HFMA) article Optimizing Patient Access (the Article), the best chance to improve the revenue cycle is at the beginning of the process when first capturing data while scheduling and registering patients. Increasing error detection processes on the front end can reduce the risk of insurance denials and late payments due to issues with a submitted claim and can also speed up the process of getting claims out the door.

Patient Access did not have an adequate process in place on the front end to identify errors in the registration process and correct them in a timely manner. The Patient Access Quality Assurance Team was limited to reviewing accuracy of new hire registrations for the first 90 days of employment. After that period, registration errors were primarily identified on the back end through issues discovered during the billing process. Error identification primarily on the back end can have a significant impact on revenue collection as undetected errors at registration can lead to delays in billing or denials by insurance.

Patient Access management established a goal for 2010 of reorganizing the Quality Assurance function to increase manual reviews to 30% of all registrations. Increasing this review to include all staff members would help identify errors related to patient demographic and insurance information as well as instances of non-compliance with policies and procedures (also see additional details on page seven related to staff performance monitoring). Management was also in the process of researching an audit tool to assure accuracy of critical fields which affect billing.

AUDITOR’S RECOMMENDATION

We recommend that Patient Access strengthen the process of detecting registration errors on the front end so they can be identified in a timelier manner. The strategy may include implementing a system to perform automated verification of key fields which impact billing. We recognize Patient Access management was working towards achieving these goals.
MEMORIAL’S RESPONSE

We are in agreement with Observation 1 that a more strengthened and timely approach to identify registration errors on the front end of our registration process would improve the efficiencies and effectiveness of our revenue cycle. Since the time of this audit, we have secured a contract with an outside firm for a Registration Quality Improvement (RQI) electronic audit tool. The contract was executed in April 2011, and we anticipate a kick-off date within the next 30 days. This system will allow us to identify registration errors real time in addition to overnight scrubbing of 100% of our registrations. We anticipate the product to be up and running within the next four to six months.

In addition to the electronic audit tool, we continue to utilize reports from our HIS system that identify errors and omissions. The reports utilized include:

- Pre-Registration Report which identifies accounts that have charges but were not activated
- Eligibility Response Maintenance report which identifies real time eligibility that was not completed
- Series Person Identification report which identifies any incorrect changes to names, dates of birth, or social security numbers
- Active Duty Military Field which identifies any person that is a military service member that we are required to allow access to patient information by the military
- Accounts not selected for billing, which shows all accounts that were not marked as “insurance verified” by our insurance analysts so that the bill drops for billing

Finally, we do have a communication channel that allows Patient Financial Services to contact our Quality Assurance staff if they identify an account that has an error that prohibits billing.
OBSERVATION 2 – PATIENT ACCESS COPAYMENT AND PRE-DEPOSIT COLLECTION PROCEDURES WERE NOT ALWAYS FOLLOWED IN THE EMERGENCY DEPARTMENT.

Patient Access personnel are responsible for collecting copayments as required by the patient’s insurance as well as pre-deposits for self-pay patients. For patients admitted to the Emergency Department, the copayment or pre-deposit is requested at checkout. According to department policies and procedures, the registrar must document a note on the patient’s account if collection was attempted and the patient stated he or she was unable to make the required payment.

Of the 23 admissions we reviewed to the Emergency Department, we noted seven instances when the required copayment or pre-deposit was not collected and there was no documentation on the patient’s account that an attempt to collect had occurred. This equates to approximately a 30% error rate.

AUDITOR’S RECOMMENDATION

We recommend that Patient Access enforce policies and procedures related to copayment and pre-deposit collections in the Emergency Department. While we recognize that collection may not always be possible, the attempt to collect should be documented by the registrar.

MEMORIAL’S RESPONSE

We are in agreement with observation 2 regarding attempts at collecting co-payments in the Emergency Department and applicable documentation. We have provided an intensive collections seminar to all Patient Access staff in August 2010, resulting in an increase in co-payment collections. Departmental goals with regard to co-payment collections have been set and we have stressed the need for appropriate documentation should collection attempts be unsuccessful. It should be noted that our registration and collection process must and does follow all necessary EMTALA requirements.
OBSERVATION 3 – PATIENT ACCESS PROCESSES WERE NOT EFFECTIVE IN PREVENTING THE CREATION OF DUPLICATE PATIENT MEDICAL RECORDS.

Duplicate patient records are typically created when at least one field of the patient’s record contains an inconsistency and the registrar does not identify the patient was already in the system as a result. These errors can occur for several reasons, including data entry problems and incorrect information provided by the patient or guarantor. Patient Access had several procedures in place to prevent the creation of duplicate records. Additional procedures were in place to detect when a duplicate record was created so the records could be combined in a timely manner.

Despite the controls in place to prevent and detect duplicate patient records, 43 duplicate medical records were identified out of a total of 134,027 registrations during the audit period. While the number of duplicates identified represents a low error rate of only 0.03%, we noted there is a potential for this type of error to cause delays in the billing process. It should be noted, however, that the duplicate records did not create duplicate patient billings.

Based on our review, proper controls appeared to be in place to prevent and detect duplicate patient records; however, controls did not appear to be working as designed.

AUDITOR’S RECOMMENDATION

We recommend that Patient Access evaluate its processes and consider why the controls were not always effective in preventing or detecting the creation of duplicate records. From this assessment, we recommend that Patient Access implement a strategy to reduce the creation of duplicates going forward.

MEMORIAL’S RESPONSE

We are in partial agreement with observation 3. Overall the number of duplicate medical records were minimal. We do have audit tools in place in order to monitor this process closely. As mentioned, a duplicate medical record does not result in duplicate billing.

The electronic auditing tool which we have purchased will assist us in eliminating this error altogether. We will be able to write rules that will identify matching patient demographic information in order to assure us that a medical record number has not already been established for each patient.

We do have an Exception Report that is utilized by Medical Records which identifies potential duplicates by matching similar information such as dates of birth, social security numbers, and demographic information.
OBSERVATION 4 – HAVING NON-PATIENT ACCESS STAFF RESPONSIBLE FOR PATIENT REGISTRATIONS AT CERTAIN OFFSITE LOCATIONS INCREASED THE OCCURRENCE OF ERRORS AND NON-COMPLIANCE WITH DEPARTMENTAL POLICIES AND PROCEDURES.

We noted there were various offsite registration locations within the health system that were not staffed by Patient Access personnel. The staff members at these locations did not receive the same new hire training as Patient Access registrars nor were they subject to the 90-day accuracy review by Quality Assurance. We reviewed 17 patient registrations for these offsite clinics and tested multiple attributes for each registration. Of the 17 accounts reviewed, there were 28 instances when errors were made or Patient Access policies and procedures were not followed (note – these instances are also included in the overall system-wide registration errors noted in Observation 1 on page 3). We noted of all the test work we performed to verify the accuracy of registration data, these areas had the highest concentration of errors.

Non-compliance with Patient Access policies and procedures at the offsite registration locations may be a result of one or more factors. These factors may include inadequate training of staff, lack of enforcement of policies and procedures, limited feedback by management when errors were made, or process modifications unique to the various registration areas.

Having these separate registration areas makes it difficult for Patient Access to effectively and efficiently manage the registration function and ensure consistency across registration locations. This can lead to increased errors and non-compliance with Patient Access policies and procedures. While these are also risks within the department, the likelihood of these types of errors occurring and going undetected increases in the non-Patient Access areas.

AUDITOR’S RECOMMENDATION

We recommend that Memorial implement a strategy to reduce the number of errors at offsite registration locations staffed by non-Patient Access personnel. The strategy may include reviewing the necessity of having offsite registration locations staffed by non-Patient Access personnel and assessing whether these areas can be combined with Patient Access. If it is determined that these registration areas need to be separate for efficiency or other reasons, the strategy may include efforts to ensure the staff are held accountable for Patient Access policies and procedures.

MEMORIAL’S RESPONSE

We are in agreement with observation 4, however; this finding is similar to observation 1. We do have areas within the hospital that have registration staff that do not report to the Patient Access Department. By implementing the electronic audit tool, we will be auditing 100% of all registrations, including those activated by non-Patient Access staff. Patient Access staff will provide education and training to those staff members and will work closely with the management teams in those areas to
require compliance with the correction processes, and the accountability standards that will be implemented along with this tool.
OPPORTUNITIES FOR IMPROVEMENT

OPPORTUNITY 1 – PERFORMANCE MONITORING ACTIVITIES FOR REGISTRARS COULD BE IMPROVED.

Registrar accuracy was only obtained and monitored against a performance standard for the first 90 days of employment. In addition, there was no accuracy standard for the registrars at the various offsite locations that were not a part of Patient Access. While Patient Access had a report that provided error information to managers, there was no formal process in place for accountability tracking. Without an established accuracy standard, performance monitoring was left to the discretion of the individual managers. This leaves room for inconsistencies in service provided across the patient registration areas and does not give registrars a target accuracy level for measurement.

According to one financial executive in the June 2008 HFMA article *Your Strategies for Improving Patient Registration Processes*; a strategy to improve accuracy is to set benchmarks by reviewing accuracy rates of top performers and then adjusting for the environment. For example, an outpatient area that is pre-registered may be evaluated against a different standard than the Emergency Department; however, all registration areas would know the accuracy standard they would be evaluated against. Having this type of performance monitoring process can motivate registrars to attain the goal and would likely also lead to more consistency across registration areas.

As part of management’s plans to reorganize the Quality Assurance function (discussed on page three), a department accuracy standard was established. Once the increased Quality Assurance efforts have been implemented, management will have accuracy rates available for all registrars.

AUDITOR’S RECOMMENDATION

We recommend that Patient Access begin evaluating registrar accuracy against a standard. This evaluation may be done in conjunction with the efforts to increase detection of registration errors through increased Quality Assurance processes. Increasing detection of registration errors will provide the necessary information for determining accuracy rates of individual registrars and will allow these results to be compared to an established accuracy standard.

MEMORIAL’S RESPONSE

We are in agreement with opportunity 1. We have established standards and begun to audit every registrar quarterly. We have been able to identify areas of concern, and have provided feedback and training to the entire staff as a result.

When RQi (electronic quality tool) is rolled out, we will be auditing 100% of all registrations. The tool will be administered by our Quality Assurance Department, and error rates are calculated by the system.
Once the RQi system is up and running, we will re-establish accuracy rates and accountability standards which will apply to all registrars throughout the department, regardless of location and Manager.
About our Office
The mission of the Office of the City Auditor is to provide City Council with an independent, objective and comprehensive auditing program for operations of the City. Our auditing program includes:

- Evaluating the adequacy of financial controls, records and operations
- Evaluating the effectiveness and efficiency of organizational operations
- Providing Council, management and employees objective analysis, appraisals, and recommendations for improving systems and activities

The Office of the City Auditor is responsible for auditing the systems used by the City of Colorado Springs and its enterprises, including Colorado Springs Utilities, Memorial Health System, and Colorado Springs Airport. We perform a variety of audits for these entities, including financial audits, performance audits, contract audits, construction audits, and information system audits. We also perform follow-up on a periodic basis to monitor and ensure management actions have been effectively implemented.

Authorization and Organizational Placement
Our audits are conducted under the authority of Chapter 1, Article 2, Part 7 of the Colorado Springs City Code, and more specifically parts 703, 705 and 706 of the Code. The Office of the City Auditor is structured in a manner to provide organizational independence from the entities it audits. This independence is accomplished by the City Auditor being appointed by and reporting directly to the City Council.

Audit Standards
This audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing, a part of the Professional Practices Framework promulgated by the Institute of Internal Auditors. The audit included interviews with appropriate personnel and included such tests of records and other supporting documentation as deemed necessary in the circumstances. We reviewed the internal control structure and compliance tests were performed. Sufficient competent evidential matter was gathered to support our conclusions.