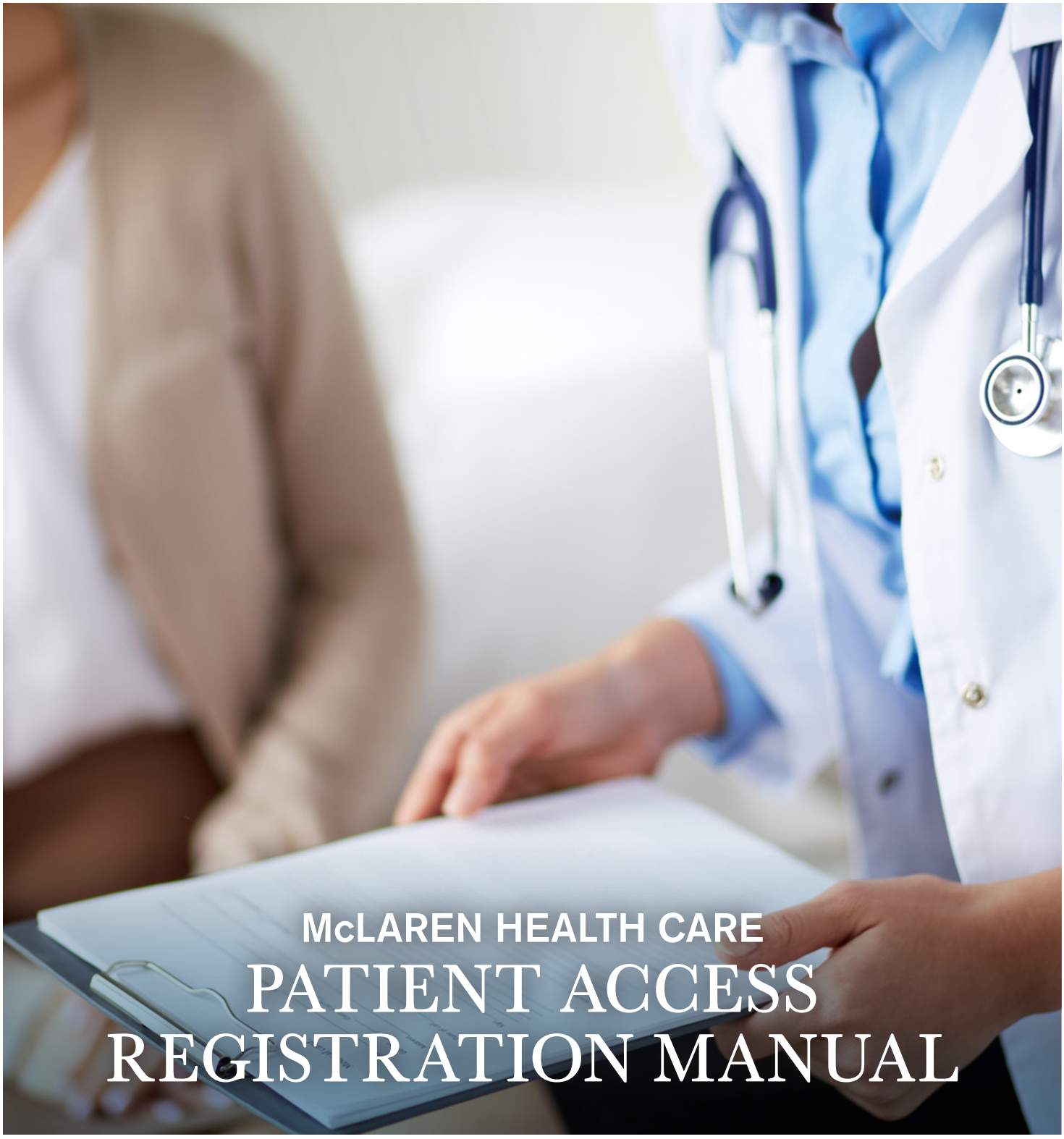


McLAREN HEALTH CARE

PATIENT ACCESS REGISTRATION MANUAL

McLaren HEALTH CARE

DOING WHAT'S BEST.®

McLaren

PATIENT ACCESS REGISTRATION MANUAL

Contents

Identity / Demographics

Patient Access plays an important role in patient identification. Proper patient identification selection is essential for the safety of all our patients. Selecting the correct patient in the electronic system is the first and most important step for patient safety. Incorrect identification and documentation can result in potential harm to the patient, delayed care, medical history, Advance Directive, and Emergency Contact information are not available to clinicians treating the patient. Specific, detailed processes have been developed to avoid errors in these areas.

Follow the Patient Demographics & Insurance Verification Policy, and the Patient Identification Policy.

A minimum of two patient identifiers must be used to correctly identify a patient (regulatory standard). We start by asking the patient to provide:

Date of Birth

Start the search by using the Date of Birth. This produces a smaller number of results to positively identify the patient. Additionally, it will reduce the amount of duplicate medical records that are created for patients.

1. Date of Birth (DOB)

Script: *"Please provide your birth date."*

Patient Name

Search for the patient using the first three letters of their last name and the first three letters of their first name. Verify the information they provide with their legal identification.

2. Patient Name

Script: *"Would you please spell your Full Legal First and Last Name for me?"*

3. Legal Form of Identification (Driver's license, ID card, etc.)

Script: *"May I see your* identification*?"*

Select the proper patient from the system.

If you are unable to locate the patient, or if the search produces many search results:

Try This!
1. Have you been seen at McLaren before?
2. Reverify their legal name and ask for a third identifier, such as their social security number.
3. Ask for possible nicknames or alias (such as their maiden name).
4. Remove their DOB and search using the first three letters of the last name, first three of the first name.

IMPORTANT: Please complete a thorough search **BEFORE** creating a new medical record. Duplicate medical records cause many issues for both patients and providers.

Creating a new Patient (medical) record:

Be very careful to ensure the patient is NOT currently in the system before creating a new medical record.

Identification information for a new patient record
1. Date of Birth
2. Full legal name, including middle name ***Ensure legal name is on the MR, ensure Guarantor Name reflects the Name on the Insurance Card.***
3. Enter suffix as appropriate (such as “junior” and “senior”)

Race & Ethnicity, Primary Language & Interpreter Needed

Data collection during patient interviews is a critical component of Patient Access. In addition to validating demographic and insurance information, other mandated fields are captured during patient registration.

Many states require hospitals to collect and report data on race, ethnicity, and language. This data provides a better understanding of the community they serve and helps to match their workforce to the communities they serve.

Race and ethnicity information is also used for grant applications, to target quality of care initiatives, and for contractual compliance obligations with government contracts, particularly Medicare and Medicaid. Additionally, race and ethnicity information help clinical staff to determine patient risks for developing certain diseases or conditions based on risk factors for an ethnicity or race.

The Patient Access staff should approach the topic of race and ethnicity with sensitivity. Before asking the questions, explain to the patient WHY we are asking.

Remember: ***You only must collect it once, IF you collect it correctly.***

Script:
“In accordance with government regulations, McLaren Health Care is required to obtain information regarding a patients' race, ethnicity, and language preference.
This information is used by the organization to improve the quality of care to our patients and the community.
Your personal information is confidential.
We value your input. You may choose not to answer these questions."

Race:

Race is based in the following five categorizations.

***Script**: Which of the following choices, best defines your race?*

American Indian /Alaskan Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment
Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
Black/African - American	A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" can be used in addition to "Black or African American."
Native Hawaiian / Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Table 1 US Census Bureau - Statistical Standards

Ethnicity:

Ethnicity determines whether a person is of Hispanic origin or not. For this reason, ethnicity is broken out into two categories, Hispanic or Latino and Not Hispanic or Latino. Hispanics may report as any race.

***Script**: Which of the following choices, best defines your ethnicity?*

Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."
Non-Hispanic or Latino	A person who does not have a Hispanic or Latino ethnicity.

Be prepared to answer questions that may arise with regards to *WHY* we must ask these questions and collect this information.

Why Are Hospitals Required to ask Race and Ethnicity Questions?
1. We ask these questions to give you better care.
2. By gathering this data, we can better prevent, test for, and treat diseases or health conditions that may affect you.
3. You may refuse to provide us with this information.
4. You will only be asked these questions once.
If the patient asks for additional information, you can explain.
Many states require hospitals to collect and report data on race, ethnicity, and language.
This data provides a better understanding of the community they serve and helps to match their workforce to the communities they serve.
Race and ethnicity information is also used for grant applications, to target quality of care initiatives, and for contractual compliance obligations with government contracts, particularly Medicare and Medicaid.
Race and ethnicity information helps clinical staff to determine patient risks for developing certain diseases or conditions based on risk factors for a particular ethnicity or race.

Language & Interpreter Needed

McLaren Health Care will ensure people with disabilities and language barriers have equal opportunity to benefit from health care services by offering interpreters for patients with hearing or speech impairment, and patients with demonstrated LEP, as well as for non-English speaking patients and family members. If requested, on-site interpreter services will be provided to the patient free of charge, and sites may use a video device if necessary.

IMPORTANT: *A patient may decline interpreter services. If the patient declines, this must be documented in the Legacy System as well as in the medical record.*

- A Patient MAY use a family member or friend to interpret, BUT this is not recommended during communication of clinical information as information can be misconstrued. A family member or friend may be helpful during the registration process.
- Even if a patient indicates they want to use a family member or friend to interpret, still offer interpreter services, and document in the Legacy system accordingly.
- If a patient declines an interpreter, but you feel that information being transmitted may not be accurate, you may request an interpreter be present for key exchanges to ensure patient safety and information accuracy.

Script:

1. *What language do you prefer to use to talk with your doctor and nurses?*
2. *In what language do you wish to receive printed materials?*
3. *Based on your response, I see that English is not your primary language.*
4. *Would you like an interpreter to help with an accurate translation of information during your time at McLaren?*

IMPORTANT: *If the patient **requires and requests an interpreter,** place a NOTE or ALERT in the system as per your site's process.*

Gender

Use a legal form of identification to document the patient's gender. If creating a new record and the gender is not apparent, or it does not appear to match the documentation, ask the following:

Script: *"We do not appear to have a gender listed, what would you like documented in your record?"*

If your current system allows, document the gender requested as such. If not, indicate in the notes section.

Transgender refers to those who were born (natal or cisgender) one gender but identify as another.
In other words, people whose gender identity (inner sense of one's gender) differs from the sex they were assigned at birth.

Transition: the process of choosing a different gender expression or physical appearance from one gender to another. This process allows the transgender person to live the life of the gender they identify as.

- Male to female (MTF)
- Female to male (FTM)

Transmale	Born Female – Identify as Male
Transfemale	Born Male – Identify as Female

Significance to the Patient
1. To prevent health disparities such as transgender people not obtaining the proper tests or exams, not being asked the right questions by providers. 2. They are at a higher risk for certain factors, including domestic violence, assault, suicide, drug, and alcohol abuse. And health risks such as cancers, cardiovascular disease, diabetes, osteoporosis. 3. They often postpone medical care, which makes diseases worsen. 4. It is recommended by the Joint Commission to provide a high-quality level of care. 5. To provide transgender patients the opportunity to provide information in a private manner. 6. To enable transgender patients to designate their gender identity and name in use even when differs from those that appear on ins or legal documents (it's not always possible for transgender people to change records due to laws and expenses).
Examples
A transgender male who was female at birth may present to the ER w/abdominal pain. *The provider will not suspect an ovarian cyst rupture or pregnancy if the patient presents as a male.*
If gender reassignment chemical (hormones) or physical (surgical) has not taken place: *A transgender female may continue to require regular prostate exams.* *Likewise, a transgender male may continue to require mammograms & PAP smears as well as birth control.*
Special consideration is the transgender community's potential reluctance to reveal gender identity/sexual orientation information for fear of discrimination or stigmatization. *This population may shy away from healthcare encounters; as a result, thereby neglecting their own healthcare needs leading to worsening conditions. There's a very high level of postponing medical care.* *Certain behaviors in the transgender community exponentially increase risk factors for sexually transmitted diseases as well as conditions associated with smoking, and silicone injections to enhance physical attributes. Diet and exercise routines may fall outside the norm, placing them at risk for nutritional deficits and imbalances.* **High school-age patients have been particularly affected by bias or discrimination in their homes, schools, churches & health care providers.** *This patient may have or may not have revealed their self-identity or orientation to others.*

Social Security Number

Ask the patient for their social security number using the following scripting:

Script: *"For your safety, we ask that you provide your social security number for identification purposes."*

1. Document the social security number in the record.
2. Reverify as appropriate for return patients.

IMPORTANT: If the patient refuses, document the account indicating the reason.

Marital Status

Ask the patient about their marital status. You may read the options available to the patient to document the correct status if necessary.

- Married
- Single
- Divorced
- Widowed

When re-verifying a current patient's marital status, ask:

Script: *"We show your marital status as _____. Is this still correct?"*

Physical Street Address

At each encounter have the patient recite their address to you.

Script: *"Would you please verify your home address."*

If the patient provides a PO Box as their address, please request an additional address for emergency purposes.

Phone Number

At each encounter have the patient recite their phone number to you.

Script: *"Please verify your primary phone number, including area code. Is this your home, work or cell phone?"*

Document the phone number, type of phone and any additional phone numbers provided.

Email Address

Email addresses must be requested from patients at every scheduling/registration check-in/admission opportunity. To continue receiving incentive payments, hospitals and providers continue to meet the meaningful use criteria.

IMPORTANT: To receive results for a guardian or minor, you must sign up using a different email address. Two portals cannot be linked to the same email address.

Script: *"What is your e-mail address?"*
DO NOT *ask "would you like to have your email address on file?"*

continued on next page…

New Patient	Existing Patient
What is your email address?	Is **** still the correct email address?
I have added *** as your email address is that correct?	Note in the patient record that the email has been validated and the date.
If the Patient Declines to supply Email Address let them know:	
Their email address will give them the opportunity to use the online resources. For example: to see their medical records online, receive patient surveys to provide feedback etc.	
It will not be sold for external marketing purposes.	
Still NO: Note in the patient record that the patient has declined to offer their email address.	
If the patient does not have an email address	
Note in the patient record that they do not have an email address.	

Religious Preference

***Script**: "Is there a religious preference you would like listed in your medical record?"*

Document the appropriate religion, or None.

Next of Kin / Emergency Contact

Document patient's Next of Kin, relationship, and contact information. The State of Michigan recognizes people with a legal or blood relationship as the patient's Next of Kin over the age of 18.

1. If a patient is legally married (as recognized by the State), the next of kin should be listed as the spouse (if legally competent).
2. If not legally married, next of kin may be determined in the following order:
   - Son or Daughter
   - Mother or Father
   - Brother or Sister
   - Grandparent or Grandchild
   - Aunt/Uncle
   - Niece/Nephew
   - Cousin

When re-verifying next of kin:

***Script:** "We show (name), your (relationship), **as your next of kin**. Is this still correct?"*

Emergency Contact

Document patient's Emergency Contact, relationship, and contact information.

When re-verifying emergency contact:

***Script**: "We show (name), your (relationship), **as your emergency contact**. Is this still correct?"*

Do's and Do NOT's of Patient Identification:

Do	Do NOT
To protect patient privacy, you may ask the patient if their Name and DOB are correct on the ID provided and enter in the system using their legal identification	Select existing record if name and DOB "almost match."
Set name alert in the system, if possible	Accept EMS run sheets as a means of identification
Verify patient's identity directly with the patient for anyone arriving via EMS	Accept Nursing Home Face sheets as a means of identification

IMPORTANT: Be Careful to Prevent Avoidable Identification Issues. Twins often have the same DOB and very similar names. Jr's/ Seniors, II & III will have the same name but different DOB.

Handling Identity Issues	
Identity Changes	Never change without direct validation from the patient, after the change or correction is made, add a note in the patient account stating the reason for the identity change.
Patient Information has been added to the wrong patient account	Notify Leadership, review scanned documents, select record that contains SSN.
Duplicate Records for the Patient	Follow the process to request medical record merge.
Suspected Red Flag/Identity Theft	Follow Identity Theft Prevention Program Policy , Set an alert in the system if able.
Unknown or Unresponsive Patient	Follow Unknown Patient Registration Policy and SOP

Check-In, Wristbands & Paperwork:

1. Prior to placing a wristband on a patient, ask the patient to re-verify their DOB and name. It is important to verify this information at every encounter!
2. Verify the band matches the patient.
3. Verify printed paperwork matches the patient.

Guardianship

A legal guardian is a person who has the legal authority (and corresponding duty) to care for the personal and property interests of another person, called a ward.

Guardians are typically used in three situations: guardianship for an incapacitated senior (due to old age or infirmity), guardianship for a minor, and guardianship for developmentally disabled adults.

- The patient legally cannot verify or consent to any medical visit
- Registration clerks need to ask every patient, every day if they have a guardian
- This needs to be noted in the patient account

1. A guardian should have paperwork with them every medical visit, if they don't politely remind them to bring documents in next visit.
2. If patient is to be admitted ask guardian to bring documents to admitting, so they can scan into the medical visit.
3. If the patient is coming from a facility check paperwork for guardian documentation.

If patient is unable to answer due to illness, injury or disability check the county court website for additional information.

County Court Website List
St Clair County: http://stclaircounty.org/dcs/search.aspx
Macomb County http://courtpa.macombgov.org/eservices/search.page.3?x=E5IQdPE3bmYnKuuT6xyUnA
Oakland County: https://secure.courts.michigan.gov/jis/entry
Wayne County: http://www.wcpc.us/Info/Info.html

Guarantor

A guarantor is a person that is financially responsible for a minor. Minor is defined as a child under the age of 18, unless emancipated.

Guardian	**Guarantor**
A person appointed by a probate court and given power and responsibility to make certain decisions about the care of another individual.	A person who is financially responsible for patient care.
Must have court papers establishing them as a legal guardian. This paperwork is only good for one year and must be brought to each visit.	Anyone over 18yrs is their own Guarantor (unless they have a guardian)
	The parent bringing a minor child in is listed as the guarantor. For example, first day Mom brings in the minor child. Mom will be the guarantor. Next day Dad brings in minor child, Dad is the guarantor.

Table 2.3 Guardian vs Guarantor Chart

How to Handle Guardian or Guarantor Situations	
Guardian	**Guarantor**
Does a guardian have the power to authorize mental health treatment? A guardian may arrange for outpatient counselling or therapy, and consent to psychotropic medication. A guardian cannot authorize inpatient psychiatric treatment if the individual objects but must instead petition the probate court and request a commitment order. A guardian cannot authorize inpatient psychiatric therefore Patient Access can and must obtain a signature from patients being voluntarily admitted to the Behavioral Health unit. If the patient has been petitioned, there is no need to get a signature from the patient unless the patient is willing to sign.	**Which Parent is the Guarantor?** The parent bringing a minor child in is listed as the guarantor. For example, first day Mom brings in the minor child. Mom will be the guarantor. Next day Dad brings in minor child, Dad is the guarantor.

Refer to site specific policies for additional information.

Port Huron Guarantor Assignment Policy

Physician Definition & Identification

IMPORTANT: Ask every patient, every time/visit. The tables below explain the overall process per system used. Please refer to specific site instructions for additional details.

For all sites: Patient access may handle the request to add physician if not listed. Otherwise, please refer to the normal processes for your site.

Paragon Sites

Physician Definitions	
Primary Care Physician	PCP/Family consider the same in Paragon. The primary physician that a patient would see outside the hospital for general care.
Family Physician	
Emergency Physician	Not Used
Admitting Physician	**Inpatient:** Attending and Admitting = The physician that admitted the patient and has agreed to be responsible for the patient's primary care while in the hospital **Outpatient:** Attending and Admitting= The physician who has ordered or signed the script for testing **ER:** Attending and Admitting = The ER physician providing care for the patient
Attending Physician	
Referring Physician	Used to send results to another or additional physician at patient's request
Consulting Physician	Not Used
Other Physician	Not Used

Physician Identification			
Primary Care Physician	**Admitting Physician**	**Ordering Physician**	**Attending Physician**
Current Process			
Collect from patient, enter in the Caregiver location in Paragon. Enter in the Physician Screen if ordering, or any other type of admission: ER, Observation, Medical, Surgical etc.	The admitting/attending physician is the physician that signed the order for service. Enter on the Physician Screen in Paragon. Enter in the Caregiver location if ordering and family/PCP are the same.	Enter the ordering physician as the admitting/attending Enter on the Caregiver screen if ordering and family are the same	The admitting/attending are always the same in Paragon. This drives orders, reports and effects other components of Paragon.

Meditech Sites

Physician Definitions	
Primary Care Physician	The patient's family Dr or physician they see outside the hospital for general care.
Family Physician	NOT USED even though is available in Meditech. ONLY PCP is used.
Emergency Physician	The ER physician providing or overseeing the care for the patient during their ER visit.
Admitting Physician	The physician who submits the order for admission (for IP and Obs. only)
Attending Physician	1. **Attending (for IP/Obs.)** = The physician who is responsible for the patient's primary care while in the hospital (starts out the same as Admitting, however can change during stay). 2. **Attending (for Outpatient)** = The physician who has ordered or signed the script for testing (physician, not PA or NP)
Referring Physician	Used by some outpatient departments for the physician that referred a patient for service but did not write the order. (For example, Physical Therapy lists a surgeon although the order might be written by someone else).
Consulting Physician	Physicians the Attending, Admitting, or ER Drs have requested to consult on the patient's care. (Unit secretaries add these on In & Obs. For outpatient, if there's more than one Dr the patient wants copied on results, we use Consulting because it allows multiple entries).
Other Physician	1. The PA or NP that signed the script for OP testing. 2. A specialist or another Dr. that the patient or ER/Attending Dr wishes to have information & results sent to (for example Cardiologist if pt. is in ER for Chest Pain, or OB if pt. has labs ordered by another Dr). 3. A non-staff physician who isn't built in our system yet ("Non-staff, Physician" gets put in the Attending field and the Other field allows us to freeform the Dr's information to be built in the dictionary later by Atos)

Physician Identification			
Primary Care Physician	**Admitting Physician**	**Ordering Physician**	**Attending Physician**
Enter in the appropriate field			

Cerner Sites

Physician Definitions	
Primary Care Physician	The physician patient sees for general care outside the hospital, patient must know correct first and last name of PCP and have seen the PCP in the last 18 months before registration will enter it in.
Family Physician	Family Physician is coupled with Primary Care Physician
Emergency Physician	Referred to in One McLaren as attending/rendering physician which could apply to ER Physician, Ordering Physician, Attending ETC.
Admitting Physician	The physician who admitted and assumes care for that whole stay, admitting never changes.
Attending Physician	**Inpatient**- Attending is the physician that will be taking care of the patient, Admitting is the physician who admitted and assumes care for that whole stay, admitting never changes. Attending can change throughout the stay as long as physician to physician has communicated and a modify admit order is performed. Registration will change the attending only if that process is completed. **Outpatient**-Attending is the physician who as signed the order for the test. (we do not use admitting for outpatient work) **ER Attending**-is physician that signs on in first net to take care of the patient.
Referring Physician	Registration will only put in referring if there is a specialist involved and its different from attending and primary care.
Consulting Physician	Registration does not put in consulting this is done by the clinical team (health unit clerks).
Other Physician	

Physician Identification			
Primary Care Physician	**Admitting Physician**	**Ordering Physician**	**Attending Physician**
Current Process			
The PCP field is required for every visit and we ask each time the patient presents. The patient must know the first and last name of the PCP and has seen them within 18 months. If patient does not know first or last name or hasn't seen PCP in the last 18 months, then we will list none, unknown and document it in our encounter comments.	Admitting doctor is in for all admission for any patient that hits a bed and it will not change. Admit order prints to registration when physician has written order. Admitting doctor is who assumes care while the patient is in house.	Admitting doctor is in for all admission for any patient that hits a bed and it will not change. Admit order prints to registration when physician has written order. Admitting doctor is who assumes care while the patient is in house.	Attending physician is place for outpatient labs, radiology's (other name ordering we do not have). Attending is also placed when patient is admitted and the only time, we can change to attending physician after admission is by a modify admit order which has to be signed by physician. Changing the attending is physician to physician. Registration will not change it unless a modify admit order is done.

Resolving Physician Identification Issues

Physician Identification Issues	
Issue	**Resolution or instructions:**
Patient Doesn't have PCP	For Cerner: Use the appropriate down selection For all others: List NONE or UNKNOWN and document it on the NOTES as well
Patient Refuses to Provide	For Cerner: Use the appropriate down selection List NONE or UNKNOWN and document in the NOTES that patient refused to provide
PCP not listed in current Caregiver list or dictionary	• Follow site's specific process for adding the physician to the Caregiver list or Dictionary
Ordering physician not on script (order)	• Do Not Accept Order • Call for New Order and try to obtain (some sites will defer to the department to get new updated order)
Ordering physician name not legible	• Ask the patient • Call the office if needed
Order is written by a PA or NP	All sites will accept
Order written/ordered by one physician but signed by another	All sites will accept
Ordering physician entered wrong and needs to be corrected	Patient Access cannot change the ordering physician after the fact if it is entered wrong. They can update, correct or reschedule under the correct physician name as appropriate if done prior to check-in. Work with HIM to correct as needed.
Updating the Attending physician, due to another physician covering	Follow your site's process for changing or updating the physician.
Referring physician or orders sent to multiple physicians	Follow your site's process to enter additional physicians in the appropriate fields.

Accident Related

When the patient presents with an accident related injury or illness, follow the appropriate Patient Access Auto/Worker Compensation Pending SOP.

Script: "Is this related to an accident?"

Then determine if the patient has insurance information.

Patient HAS their insurance information	Patient Does NOT have their Insurance Information
1. Enter the insurance (auto, medical, WC or claim) information available at the time of registration into the HIS (health information system)	1. Provide patient with the Auto/WC Pending Information Request Letter to fill out and return to patient access for the account to be updated.
2. Remove any special holds that were on the patient account (Auto/WC Pending) if needed	2. Update the insurance plan code to "Auto Pending" or "Workers Comp Pending"
	3. **For Non-Cerner Millennium Sites:** Place the account on a special hold titled, "Auto/WC Pending."

For additional information please refer to the Non-Cerner Millennium SOP.
For additional information please refer to the Cerner Auto-Workers Comp Pending SOP

Accident Type

When a patient has been in an accident, use the scripting below to help determine the appropriate way to bill:

Script:

1. Your first question when a patient presents should always be, "Is this an **Accident Related Visit**?" (If yes, enter "Yes" in the system and the following additional fields will populate:
2. Once you have determined it is an accident related visit, ask the patient to "Please tell me the following information in as much detail as possible:" (Be sure to capture all the information)
    a. "What type of accident?" **(Accident/Onset Type)**
    b. "On what date did the accident occur?" **(Accident/Onset Date)**
    c. "At what time?" (**Accident/Onset Time)**
    d. **"**Last, please tell me the state the accident occurred in." "Did this accident take place in Michigan?" **(Accident/Onset State)**

Auto

Auto Accidents & Application of Michigan NO Fault Laws: This procedure will not cover every aspect and situation that may be encountered due to the diversity of each case.

Consider this:

Some cases, such as slamming your hand in the car door for example, may not seem like an "auto accident" to a patient, even though it is classified as such. To avoid getting denials in which we don't bill **"auto"** when we should, it is very important that you ask all the questions above, every time you're dealing with a patient that has been in an accident.

Insurance:

It is important we always enter the Patient's Health Insurance information, as well as Auto Insurance, in case authorizations are needed.

Michigan No-Fault insurance laws apply, the following is the priority:

1. **Enter the Patient's own AUTO INSURANCE as Primary –**
   a. Regardless if it was the Patient's personal car involved in the accident or not; whether they were a pedestrian, passengers or the driver makes no difference.
   b. If the Patient does not know their auto insurance information, enter **AUTO PENDING** as primary insurance and medical insurance as secondary.

OR

2. **Enter the Patient's own MEDICAL *INSURANCE when the Patient can state that their Health Insurance is Primary***
   a. This is never the case with Medicare or Medicaid.
   b. Please note: This will not be the likely scenario. Typically, auto will be primary, but select plans will be the primary payer over auto.
      i. Enter Health Insurance as Primary
      ii. Auto as secondary

OR

3. **Provide the Patient with the Auto/WC Pending Letter** and explain why it is vital for them to return the information within 14 days. The AUTO/WC PENDING SOP is to be followed.

SCRIPTING: *"Since you do not have your Auto / WC insurance information available, it is very important that you return this letter to us within 24-48 hours so that we can properly bill your insurance for the services provided so that you will not be directly billed and responsible for paying for these services."*

Always scan Auto Insurance cards as well as health insurance cards.

Michigan No-Fault

Auto No-Fault insurance applies when an accident involves at least one **four-wheeled vehicles** (excluding ATVs unless operated on a public road).

Auto No-Fault Covers these Examples	**Personal Health Insurance Covers these examples**
• Car/truck or Cars involved in a collision	• Motorcycle only
• Car/truck hitting a pedestrian	• Motorcycle hitting a tree
• Car/truck hitting a motorcycle	• Snowmobile only
• Car/truck hitting a tree	• Bicycle hitting a parked car
• Snowmobile hitting a car	
• Bicyclist collides with a car	
No-fault coverage does not extend to a parked motor vehicle unless the Patient was injured while entering or exiting, unloading, or providing maintenance to a motor vehicle.	

Once it has been determined that the injured person has been involved in an accident where Michigan No-Fault insurance applies, the following is the priority order (1st A is primary, if not A then B, etc.) on which you would determine what insurance is primary:

A. Own personal auto insurance (regardless if it was your car or whether you were the passenger or driver).

Example: *You are a passenger in a friend's car and are broadsided by another car.* ***Your*** *personal auto insurance is Primary for any injuries you sustained.*

B. If the injured person does not have Auto insurance, then the Auto insurance of spouse or relatives domiciled in the same household would be Primary.

Example: *A child is injured while a passenger in a friend's motor vehicle. That child's parent's auto insurance is Primary for any injuries sustained by the child.*

C. If neither the injured person nor any relative in their household has Auto Insurance, then the Auto insurance of the owner or registrant of the vehicle is Primary.

Example: *The passenger in a motor vehicle is injured; however, neither the passenger nor any relative in their household has Auto insurance—the owner of the auto that they were injured in or by would-be Primary.*

D. If the vehicle is not insured by the owner, then the Auto insurance of the driver of the vehicle would be Primary.

Example: *The car involved in a collision is uninsured by the owner, and a person other than the owner is the driver of the car when you were injured as a passenger. Neither you nor a relative in your household has auto insurance. The drivers Auto insurance would be Primary.*

Ultimately, a person entitled to no-fault personal injury protection insurance benefits will get those benefits, even if no insurers in the A-D priority scheme exist, since the insurer of last resort in each instance is named by *Michigan's Assigned Claim Plan*.

A person's Health Insurance is the first payer in a vehicle accident, **ONLY** if the Patient's personal health insurance provides first-line coverage (Few health insurance companies offer these plans). <u>This is never the case with Medicare or Medicaid.</u>

<u>IMPORTANT:</u>

- If the Patient does not communicate this to you without asking or doesn't know, **assume that Auto Insurance will be the primary insurer.**
- *Make sure to enter the patients' health insurance as the secondary insurance on their account in the system.*

Employer Owned Vehicle: Employers insurance is Primary

If no active automobile insurance is in force for any of the above situations, the patient may be entitled to benefits through:

Assigned Claims Facility

Michigan Department of State

Lansing, MI 48918

(617) 322-1875

Occurrence Codes: Make sure to enter the **Occurrence Code (Click to navigate to page)** as appropriate per the System used at each site.

Scheduled Auto/WC Appointments: For Patients coming in for scheduled testing and procedures related to Auto/WC related injuries or illnesses:

- MUST have the Auto/WC insurance information and claim number available at the time of scheduling, as well as any needed authorizations. If the information mentioned is missing, the testing or procedure is to be rescheduled/postponed until the missing information is provided.

Letter

If the patient does not have their Auto or Workman's Compensation Information at the time of service, please provide them with the Patient Access Auto Insurance letter to prompt them for the needed information.

Insurance

Participating and non-participating (PAR or Non-PAR)

McLaren Health Care participates with (or accepts) many different health plans. This is referred to as PAR = participating in health plans & Non-PAR = Non-participating health plans.

IMPORTANT: McLaren locations accept **DIFFERENT** Insurance Plans. And the list of PAR Non-PAR does change.

Please use the McLaren Website Participating Health Plans to view the updated listings of participating or non-participating insurance plans.

Network vs. Out of Network

Network - a group of doctors, hospitals, and other health care providers work with insurances to provide services at discounted rates.

In-network provider - a provider that is part of a health plan's network of preferred providers. Patients will generally pay less out of pocket.

Out-of-network provider - a provider that is not part of a health plan's network of preferred providers. Patients will usually pay more out of pocket.

Primary Insurance

Primary insurance is a policy that pays for **coverage** first, even when the policyholder has other policies that cover the same risk. Those other policies will only be tapped when the **primary** policy has reached its financial limit.

Secondary Insurance

Secondary insurance, as the term implies, is insurance coverage that is available in addition to any primary policy that an insured may carry. It is often used to supplement existing policies or to cover any gaps in insurance coverage. It may also be present when two spouses have coverage through different employers.

Tertiary Insurance

Tertiary insurance is a third policy. When you have multiple insurance policies, such as if you have Medicare and a supplemental policy, it's possible to have more than one covering a given procedure or loss. The third one to be billed is referred to as tertiary coverage.

Coordination of Benefits

It is important for patient access associates to obtain **all** insurance information from the patient and record them in the patients account to ensure patients insurance coverage.

The way coordination of benefits works is that one health insurance plan becomes identified as the primary health insurance plan. Then, the second one is the secondary plan. In the event of a health insurance claim, the primary health insurance plan will pay out first, then the second one will kick in to pay towards the remaining cost that the first plan didn't cover completely.

The following list identifies some common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer.

Here is a list of situations and which plan would likely serve as primary and which ones would likely be secondary:

Situation	Who's primary	Who's secondary
You're married and both you and your spouse have separate health plans	Your employer	Your spouse's employer
A child has dual coverage by married parents	Whichever parent has the first birthday in calendar year	Parent with later birthday
A child has divorced parents	Whoever has custody	--

Situation	Who's primary	Who's secondary
A child has own policy (from school or work) and still on parent's policy until 26	Child's plan	Parent's plan
A child is married and on spouse's policy and continues on parent's policy until 26	Child or child's spouse's plan	Parent's plan
A child under 26 is pregnant and on a parent's plan	Child's plan	--
Workers' compensation and health insurance plan	Worker's compensation	Health plan
Workers' compensation and health insurance plan	Worker's compensation	Health plan
COBRA and other insurance	Employer's plan	COBRA
Medicare and a private health insurance plan	Medicare if employer has 100 or fewer employees; private insurer if more than 100 employees	Private insurer is 100 or fewer employees; Medicare if more than 100 employees
Veterans Administration (VA) and a private health insurance plan	Private insurer	--
Military coverage (TRICARE) and other health insurance	Other insurer	TRICARE except if other plan is Medicaid

Table 3 COB Chart

Additional Scenarios in the above instances:

A child has dual coverage by married parents
In this case, the so-called "birthday rule" will apply. This means whichever parent has the first birthday in a calendar year is the one whose insurance plan is considered primary. Remember - it's not who is oldest. It's where the birthday (month and day) falls in the calendar year. If parents have the same birthday, the primary coverage will go to the plan that has covered a parent longer.
A child has divorced parents
The child is usually covered by the parent who has custody. If the child's custodial parent remarried, the stepparent's plan may provide secondary coverage for the child. The plan of the parent who doesn't have custody usually pays last. If it's joint custody, the birthday rule usually applies. Note: A divorce decree may also influence which plan is primary. If the divorce states that one parent is financially responsible for the healthcare expenses of the child, then that parent's plan should be primary for the child and the other parent's policy is secondary. If the decree states that both parents are responsible, then their plans would be given the same priority, thus reverting back to the birthday rule for whose would pay first.

A child under 26 is pregnant and on a parent's plan
The health insurance status would stay the same for the under 26 child; the parent's insurance serves as secondary. However, the newborn is different. Once the child is born, he/she will need to be covered by his/her parent - not his/her grandparent. The grandchild is not a dependent to the grandparents, thus their insurance would not extend to that child.
Medicaid and a health insurance plan
Medicaid is always the payer of last resort when there are multiple plans.
Veterans Administration (VA) and a private health insurance plan
VA is not considered a health insurance plan. Instead, the VA bills public or private health insurance providers for care, services, prescriptions, and supplies. So, if your spouse has a health insurance plan it would be your health plan. The VA is not insurance.
Military coverage (TRICARE) and other health insurance
TRICARE is considered secondary to all other health plans except Medicaid, TRICARE supplements, state crime compensation programs and other specified federal government programs. Note: If you are on active duty you can't use any other health insurance. TRICARE is your only health insurance coverage.

Table 4 COB Scenarios

1. Working Aged (Medicare beneficiaries age 65 or older) and Employer Group Health Plan (GHP):

- *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has less than 20 employees:*
  Medicare pays Primary, GHP pays secondary
- *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
  GHP pays Primary, **Medicare pays secondary**
- *Individual is age 65 or older*, is *self-employed* and covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
  GHP pays Primary, **Medicare pays secondary**

2. Disability and Employer GHP:

- *Individual is disabled*, is covered by a GHP through his or her own current employment (or through a family member's current employment) AND the employer has 100 or more employees (or at least one employer is a multi-employer group that employs 100 or more individuals)
  GHP pays Primary, **Medicare pays secondary**

3. End-Stage Renal Disease (ESRD):

- Individual has ESRD, is covered by a GHP and is in the first 30 months of eligibility or entitlement to Medicare
  GHP pays Primary, **Medicare pays secondary during 30-month coordination period for ESRD**
- Individual has ESRD, is covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA plan) and is in the first 30 months of eligibility or entitlement to Medicare
  COBRA pays Primary, **Medicare pays secondary during 30-month coordination period for ESRD**

  Please see the **ESRD** page for more information.

4. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – the law that provides continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.

- *Individual has ESRD*, is covered by COBRA and is in the first 30 months of eligibility or entitlement to Medicare COBRA pays Primary, **Medicare pays secondary during 30-month coordination period for ESRD**
- *Individual is age 65 years or older* and covered by Medicare & COBRA:
  Medicare pays Primary, COBRA pays secondary
- Individual is disabled and covered by Medicare & COBRA:
  Medicare pays Primary, COBRA pays secondary

5. Retiree Health Plans

- *Individual is age 65 or older* and has an employer retirement plan:
  Medicare pays Primary, Retiree coverage pays secondary

6. No-fault Insurance and Liability Insurance

- *Individual is entitled to Medicare and was in an accident or other situation where no-fault or liability insurance is involved.*
  No-fault or Liability Insurance pays Primary for accident or other situation related health care services claimed or released, Medicare pays secondary

7. Workers' Compensation Insurance

- Individual is entitled to Medicare and is covered under Workers' Compensation because of a job-related illness or injury:
  Workers' Compensation pays Primary for health care items or services related to job-related illness or injury claims. Medicare generally will not pay for an injury or illness/disease covered by workers' compensation. If all or part of a claim is denied by workers' compensation on the grounds that it is not covered by workers' compensation, a claim may be filed with Medicare. Medicare may pay a claim that relates to a medical service or product covered by Medicare if the claim is not covered by workers' compensation.

  Note: When there is evidence that the no-fault insurer, liability insurer, or workers' compensation plan will not pay promptly, Medicare may make a conditional payment. A conditional payment is a payment Medicare makes for services another payer may be responsible for. Medicare makes this conditional payment so that the beneficiary won't have to use his own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment, award or other payment is made.

Federal law takes precedence over state laws and private contracts. Even if an entity believes that it is the secondary payer to Medicare due to state law or the contents of its insurance policy, the MSP provisions would apply when billing for services.

Source: CMS website, https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

Medicare Secondary Payer Questionnaire

Providers must determine if Medicare is the primary or secondary payer. Failure to do so is a violation of the provider agreement with Medicare

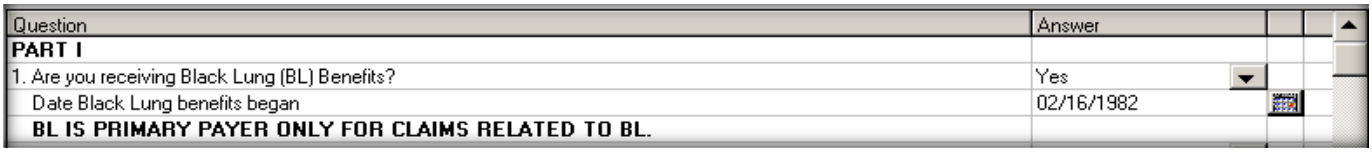
When would I fill out the MSP questionnaire?
You are required to ask the MSP questions when the patient has a straight Medicare policy as a primary or secondary insurance.

If a patient has a Medicare advantage plan we are not required to ask or fill out the MSP questionnaire.

- For example, if the patient has Medicare Plus Blue, Humana Gold, BCN Advantage, etc., you do not have to fill out the questionnaire.

Part I- Black lung, government research, and veteran affair benefits

Question 1

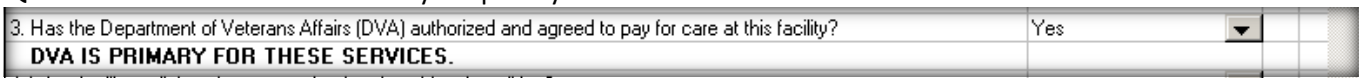


If they answer yes to question 1, enter the date Black Lung Benefits began.

Question 2

Are the services to be paid by a government program such as a research grant.

Question 3 is answered incorrectly frequently.



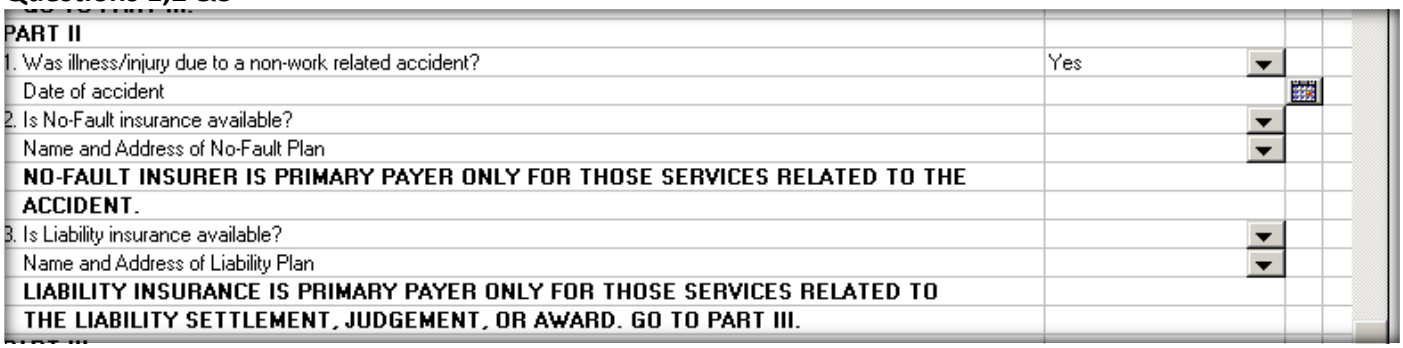
If the VA is paying for this date of service, you must answer yes

Question 4

If the answer is yes, please entering the date of the injury or illness. Please note, if Workers Compensation is paying, we need the information and claim number

Part II Questions

Questions 1,2 &3



If the illness or injury is due to a non-work-related accident, we must have the insurance information and claim number. Make sure to ask the patient all three questions.

Part III- Medicare Entitlement

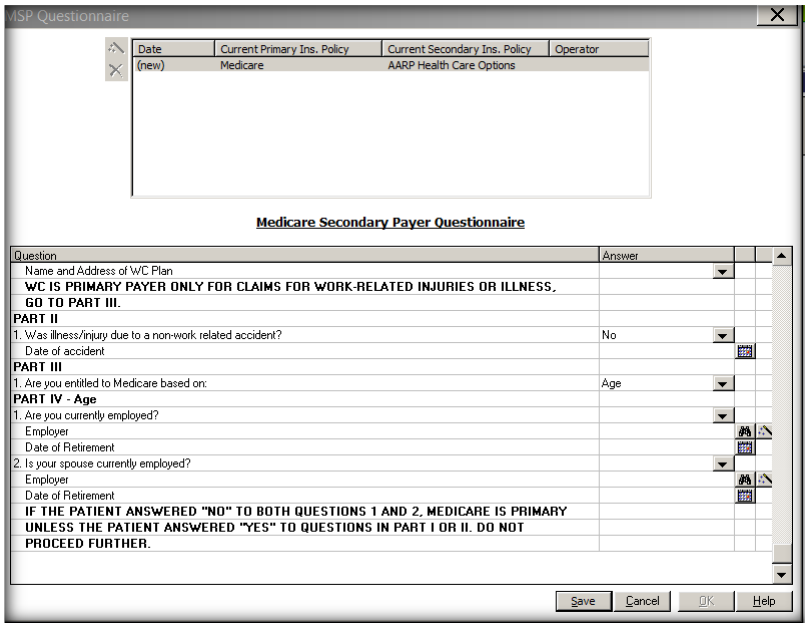
Is the patient eligible for Medicare based on?

- Age
- Disability
- End Stage Renal Disease (ESRD)

Part IV- Age

If the patient is eligible for Medicare due to age, you must answer the additional questions of employment.

1. Is the patient currently employed?
    a. If "No," enter the retirement date
    b. If "Yes," enter the employer's name
2. Is the spouse currently employed?
    a. If "No," enter the retirement date
    ○ If "Yes," enter the employer's name



What if the patient cannot recall the date if retirement?

- When a beneficiary cannot recall his/her retirement date, but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, hospitals report his/her Medicare Part A entitlement date as the date of retirement.

- If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, hospitals report the beneficiary's Medicare entitlement date as his/her retirement date.

- If the beneficiary worked beyond his/her Medicare Part A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but the hospital determines it has been at least five years since the beneficiary retired, the hospital enters the retirement date as five years retrospective to the date of admission. (Example: Hospitals report the retirement date as January 4, 1998, if the date of admission is January 4, 2003)

As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

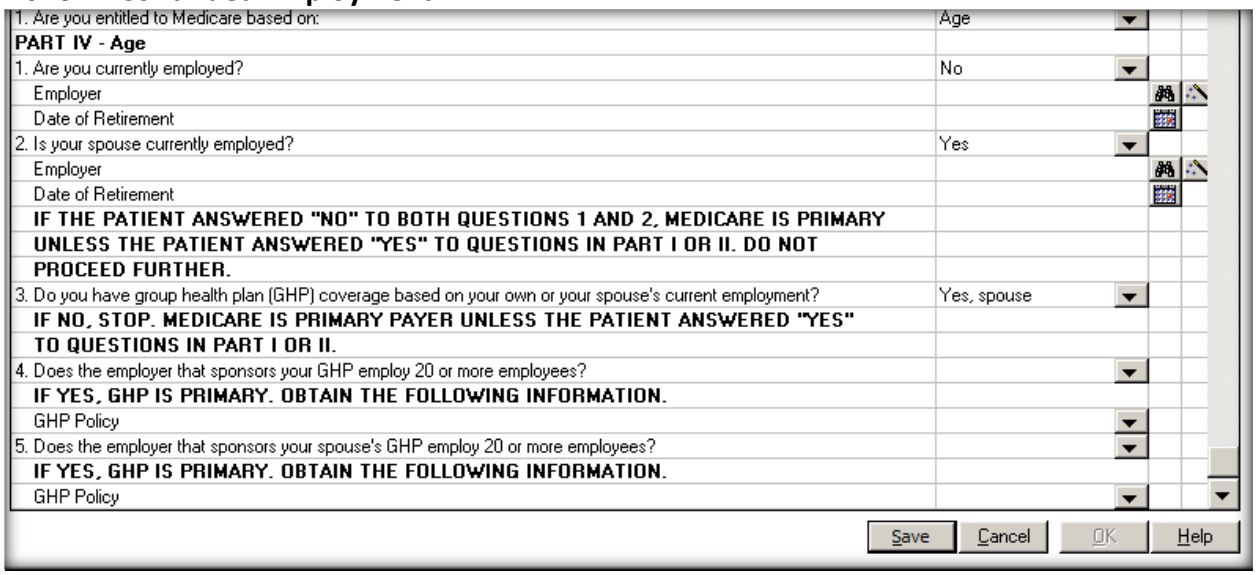
- If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the hospital must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

Pro Tip: If they absolutely cannot remember the retirement date, please use the date they were eligible for Medicare Part A (it is listed on their Medicare card and in CSNAP.

If the patient answered "no" to questions one and two (Are you employed? Is your spouse employed?) Medicare is Primary. And you are finished with the MSP questions.

If the patient or spouse is employed, you must answer question three.

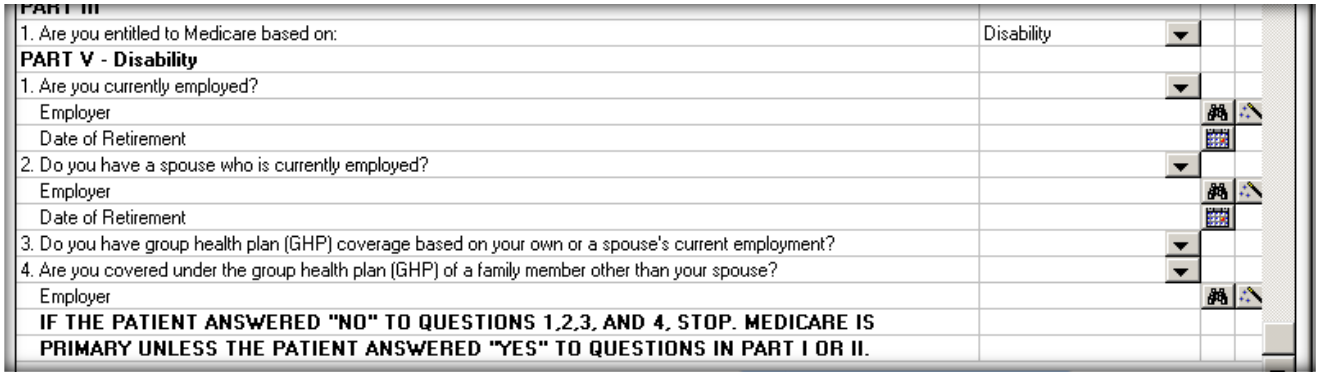
Part IV Continued Employment



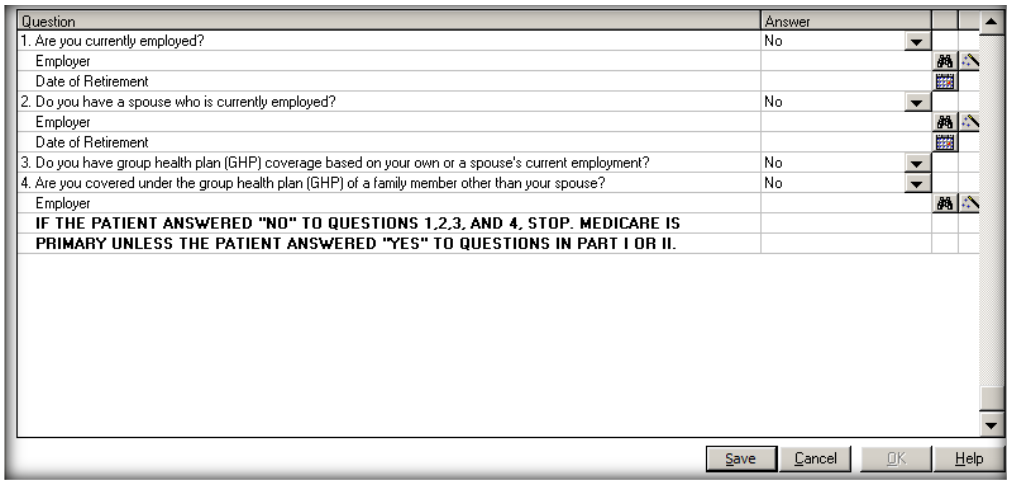
It will then open up a new series of questions. Ask the patient questions four and five and answer accordingly.

Part V- Disability

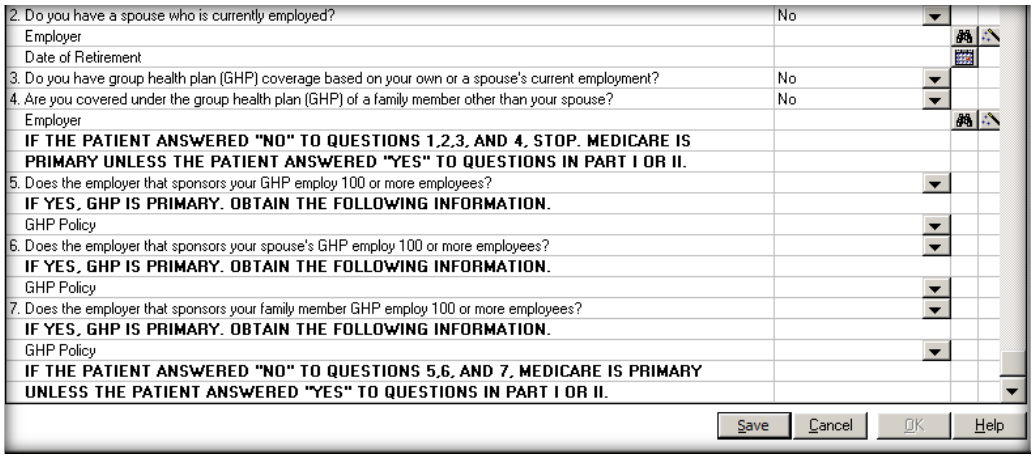
If the patient is eligible for Medicare due to disability you must answer the questions.



If the answers to 1,2,3 and 4, are no you can stop. And you are finished with the MSP questions.



If the patient or spouse is employed, you must answer questions 3-7.

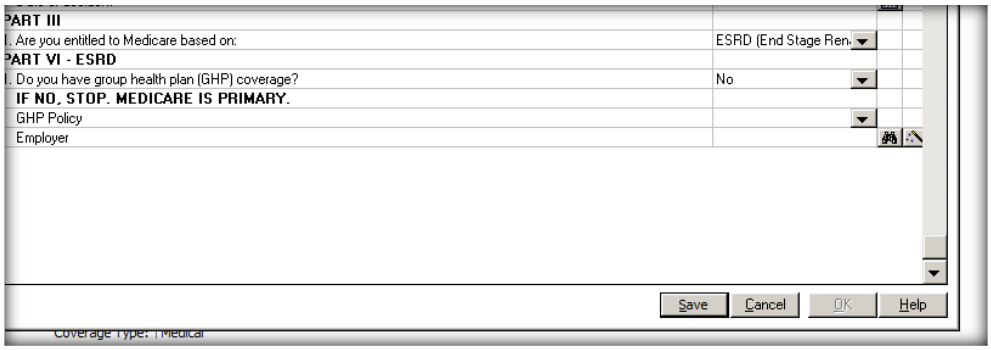


Part VI- ESRD

If the patient is eligible to Medicare due to ESRD, ask question one.

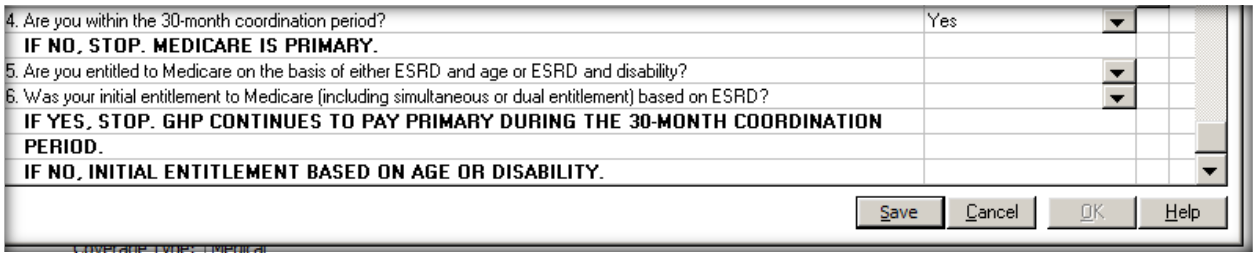
- If the answer is no, you may stop.

Medicare is primary. And you are finished with the MSP questions.

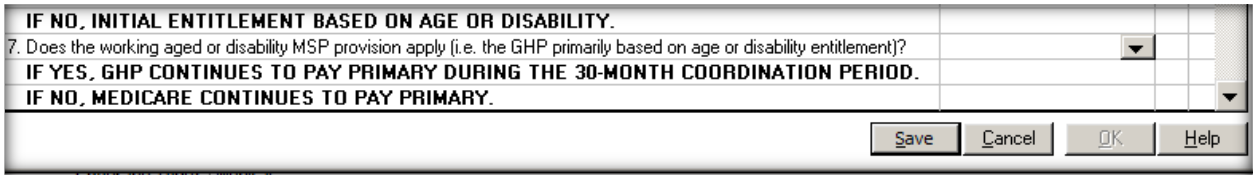


If the answer is yes, you must ask questions 2-4, which discusses kidney transplant and dialysis.

If the answer to number four is yes, you must ask question five and six.



If the answer to number six is no, it will open question seven. Answer yes or no.



Medicaid Spenddown

Patients cannot qualify for Medicaid coverage until they meet their individually set out-of-pocket expenses. Patient Access staff will identify patient accounts with spend down amounts during eligibility checks.

STEP 1: Scheduling schedules a patient appointment greater than or equal to 3 days prior to date of service.
STEP 2: Patient Access Registration performs insurance verification via financial clearance tool.

For additional information refer to the Patient Access Medicaid Spenddown SOP.

Self-Pay Referrals to EAV

Patient Access associates can refer patients to our Eligibility Assistance Vendor for financial assistance.

STEP 1: Patient presents in the emergency department.
STEP 2: Registration performs a quick registration.
STEP 3: The patient medical screen is completed by clinical staff.
STEP 4: Registration updates registration including insurance verification.

For additional information refer to the Patient Access EAV Referral SOP.

Scanning Forms

There are several forms and documents that must be included in the patients record. These documents include copies of the patient's identification and insurance cards. It also includes ABN (Authorized Beneficiary Notice)

Scan Driver's License, Insurance Card and Legal Documents

Ask every patient, every time for their ID and insurance card.

***Script**: "May I see your ID and Insurance Card please."*

IMPORTANT: Be aware of Red Flags for identity theft.

What is a Red Flag?
A pattern, practice or specific activity that indicates the possible existence of Identity Theft. Patterns, practices and specific activities signaling possible Identity Theft
Examples of Red Flags
Patient presents for an episode of care and is recognized as someone other than the patient presenting him/herself to be.
Patient submits a driver's license, insurance card or other Identifying Information that appears to have been altered or forged.
Photograph on a driver's license or other photo ID card submitted by the patient does not resemble the patient.
Information on one form of identification submitted by the patient is inconsistent with information on another form of identification, or with information already in the Hospital's records.
Discrepancies between admissions information and prior account information or current insurance eligibility information.
The physical address provided by the patient is known not to exist, or the patient cannot provide anything other than a post office box as physical address.
Address or name discrepancy on identification or insurance information.
The Social Security Number (SSN) furnished by the patient has not yet been issued, is listed on the Social Security Administration's Death Master File or is otherwise invalid.

Table 5 Red Flag Table

For additional information on Red Flags reference the Identity Theft Prevention Policy.

Forms Offered During Registration

Patient Access associates are required to offer the following forms to McLaren patients. This ensures that McLaren remains compliant with government regulations and agencies.

Notice of Privacy (aka HIPPA)	The notice must also contain a statement of the patient's rights with respect to PHI. These rights include: The right to request restrictions on certain uses and disclosures of PHI. The right to receive confidential communications of PHI, as permitted by law.
General Consent	The main purpose of the informed consent process is to protect the patient. A consent form is a legal document that ensures an ongoing communication process between you and your health care provider.
Patient Rights & Responsibilities	Otherwise referred to the Patient Bill of Rights
FA Plain Language Summary	Financial Assistance Plain Language Summary
Advanced Directive (AD)	An **advance directive** is a legal document that explains how you want medical decisions about you to be made if you cannot make the decisions yourself.

Please refer to local site policies for access and delivery instructions for the forms.

Minor Registration (exception – Medicaid)

CONSENT GUIDELINES FOR TREATMENT OF MINORS AND GUARDIANSHIP ASSIGNMENT

Patient circumstance:	Is consent of **parent or guardian** required?	Is consent of **minor** required?	Are **parents or guardians responsible for cost**?	Who is listed as **guarantor**?
Under 18, unmarried, no special circumstances	Yes	No	Yes	Parent or Guardian
Under 18 and in an ***emergency*** medical situation with no parents available	No	No	Yes	Parent or Guardian
Under 18, **unmarried**, **pregnant** and **care is related to pregnancy**	No	Yes	No	Patient
Under 18, **unmarried**, **pregnant**, **care NOT related to pregnancy**	Yes	No	Yes	Parent or Guardian

Parent is under 18 and their **child needs treatment**	Parent under 18 may sign for treatment of their child	N/A	Parent under 18 is responsible for cost	Parent under 18
Under 18 and emancipated by: court action (request proof of emancipation from court) being legally married/divorced being on active duty with the U.S. Armed Forces claim to be emancipated, no documentation available	No	Yes	No	Patient
Under 18 and care is for any suspected **contagious reportable disease** or disease dangerous to the public health (STD/HIV etc.)	No	Yes	No	Patient

Consent for phone message

Read the consent to the person on the phone for verbal consent. Two registrars must be present and both will attest to the witness of consent by signing and dating (date and time) and scan it into the system.

If the patient is unable to sign or due to mental status, for example, cannot complete consent, we can proceed with verbal consent over the phone.

VIP (One-McLaren Cerner)

If an Executive or Board Member presents for service, select “McLaren Executive” in VIP indicator drop down.

Occurrence & Condition Codes

Occurrence and Condition codes can be added to the patient account at the time of registration. See specific Codes used by HIS System below.

Paragon Sites

Code Type	Code	Description
Condition Code	**99**	When a patient has multiple AUTH's on the UB tab in Paragon in the bottom right corner there is a Condition Code box. In this box select 99 which states reserved. This will stop the claim at the CBO so they can place all AUTH's on the claim.
Occurrence Codes	**01 – Accident/Medical Coverage**	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
	02 – No Fault Insurance	Code indicating the date of an accident including auto or other where state has applicable no fault liability laws. (i.e. – legal Auto Accident/Other basis for settlement without admission or proof of guilt.) **All Michigan located 'auto' accidents (NOT MOTORCYCLE)**
	03 – Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. **(Slip and fall in grocery store, businesses, etc.)**
	04 – Accident/Employment Code	Indicating the date of an accident allegedly relating to the related patient's employment
	05 – Other Accident	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury. **(Motorcycle)**
	06 – Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
	11 – Onset of Symptoms/Illness	Code indicating the date on which a medical condition started or began. **Not related to accident or injury.**
	17 – Date OP Therapy	
	18 – Retirement Date Patient	
	19 – Retirement Date Spouse	
	35, 44, 45 **46 - Date treatment started for Cardiac Rehab**	To be added by Therapy as appropriate

Meditech Sites

Code Type	Code	Description
Condition Codes	•Patient Access do not use Condition Codes	
Occurrence Codes	**01 – Accident/Liability**	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
	02 – Auto Accident, No Fault	Code indicating the date of an accident including auto or other where state has applicable no fault liability laws. (i.e. – legal Auto Accident/Other basis for settlement without admission or proof of guilt.) **All Michigan located 'auto' accidents (NOT MOTORCYCLE)**
	03 – Accident, Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. **(Slip and fall in grocery store, businesses, etc.)**
	04 – Accident, Employment Related	Indicating the date of an accident allegedly relating to the related patient's employment
	05 – Other Accident	Code indicating accident related injury for which there is no medical payment or third-party liability coverage. Provide the date of accident/injury. **(Motorcycle)**
	06 – Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
	32 – When a Patient signs an ABN	No current policy, it's built into Meditech; add at time of registration
	IMPORTANT: Occurrence Codes for Injuries 02, 04, 05, 06 – We use these along with accident information (Meditech screen shots provided below). We don't use 01 or 03 in Registration. We only choose 02 for all auto accidents, 04 for all employment related, 06 for crime victims, and 05 for all others.	

Mnemonic	Name
01	01 Accident, Liability
02	02 Auto Accident, No Fault
03	03 Accident, Tort Liability
04	04 Accident,Employment Related
05	05 Other Accident
06	06 Crime Victim

Cerner Sites

Code Type	Code	Description
Condition Codes	Not Used	
Occurrence Codes		Add at time of registration; Manager adds
	32 GA Modifier	This can only be added under the Patient Accounting Conversation

Incarcerated Patients

When registering patients who are incarcerated in a **State of Michigan Department of Corrections** facility, complete the following steps. (**Does NOT apply to local correctional facilities).**

STEP 1: Michigan Department of Corrections (MDOC) patients are scheduled and financially cleared prior to the date of service (DOS) (Check secure box for all MDOC registrations).

STEP 2: If the patient is being registered for inpatient services, Patient Access will register the patient with 'MCD-HMP Incarceration' as primary insurance.

I. If the Medicaid primary insurance is active, no further action is needed.
II. If the Medicaid primary insurance is not active place account on special hold
III. Verify active Medicaid coverage through CHAMPS within 2 weeks following pre-registration, release special hold and submit claim for billing.

STEP 3: If the patient is not being registered for inpatient services, Patient Access will register the patient with Blue Cross Blue Shield (BCBS) as primary insurance.

I. If the BCBS primary insurance is active, no further action is needed.
II. If the BCBS primary insurance is not active, place on special hold in the system. Contact the prison for updated health plan and information # for prisoner
III. Upon active BCBS coverage, release hold.

For additional information refer to the State Incarcerated Patient SOP.

For more information regarding local jail facilities: Please refer to your site-specific process for registration of patients incarcerated locally.

Homeless Registration

Follow the Homeless Registration Policy and the accompanying Homeless Registration SOP.

All homeless patients that are identified and registered with no current address at the time of visit, should reflect as such to ensure statements are not produced.

According to the Homeless Registration Policy and SOP the address should be:

HOMELESS, Fenton, MI 48430

For **Lansing**, use the "Homeless" Dropdown option in Cerner.

Newborn Admission Registration

STEP 1: Obstetrics Department contacts Patient Access upon delivery of a newborn baby.

STEP 2: Obstetrics Department is to provide the name of the newborn and mother's information.

I. On a weekly basis, Obstetrics Department is to inform HIM the newborn birth certificate has been received.

STEP 3: Patient Access registers the newborn following the baby naming convention.

I. If a newborn is to be surrendered to State, Patient Access will refer the account to EAV.
II. If not, Patient Access will verify if Medicaid coverage is active on the account.
III. If Medicaid is not active on the newborns account, Patient Access will register newborn under mother's insurance.
IV. If Medicaid is active on the newborn account, Patient Access will register newborn with Medicaid.
    A. Place newborn account on Newborn Special Program Hold.
    B. Meet with the mother to complete and obtain mother's signature for the MSA-565-C Form for newborn enrollment into Medicaid.
    C. Submit a copy of the MSA-565-C Form to MDHHS Office and retain the original in the beneficiary file.

For Additional Information Refer to the Newborn Admission Registration Policy. And the Patient Accounting Non-Cerner Newborn Adds SOP.

Nonresponsive Patient

This policy is used when a patient cannot be identified. Use the enterprise standard to allow unidentified patients to be treated without delay.

STEP 1: Patient presents to the Emergency Department (ED), identity is unknown/patient is unresponsive.

STEP 2: Registrar refers to ED Unknown Patient Log (Attachment 1) for next available name.

STEP 3: Registrar selects next available name from the ED Unknown Patient Log.

STEP 4: Registrar quick registers the patient using the name from the Emergency Department Unknown Patient Log.

STEP 5: Patient receives medical screening in parallel to obtaining patient identification.

STEP 6: Registrar will determine if the patient can be identified.

I. If the patient can be identified, Registrar will complete full registration for the patient, and adds new band to patient with the updated information.

IMPORTANT: DO NOT REMOVE ORIGINAL BAND. Both bands will remain on the patient.

II. If the patient cannot be identified, leave the patient registered and banded as an unknown patient. Process terminates

STEP 7: Registrar will complete the additional information in the Emergency Department Unknown Patient Log (Legacy) or ED Incomplete Reg Worklist (Cerner).

STEP 8: Once the patient is identified, Registrar will update the encounter and determine if the patient is an existing McLaren patient.

I. If the patient is an existing McLaren patient, work with Health Information Management (HIM) to combine medical records for the patient after discharge.
II. If the patient is not an existing McLaren patient, the registration is complete and do not combine accounts.

For Additional Information refer to the Unknown Patient Registration Policy. And the Unknown Patient Registration Policy SOP.

POS Collection & Financial Clearance

Patient Centered Financial care is the culture that we embody at McLaren. We endeavor to provide transparent costs for healthcare services, assist our patient in understanding their coverage and offer flexible payment options.

STEP 1: Patient presents/receives services at a McLaren site

I. If patient is an Emergency Department Admission, check patient's insurance
    A. If patient is insured, communicate insured script otherwise communicate a self-pay/no insurance script and end process

STEP 2: Scheduling and non-emergency

I. If patient is non-emergency check to see if they are scheduled
    A. If patient is scheduled for same day of service, communicate DOS requests for scheduled procedures script and end process
    B. If patient is not scheduled for same day of service, check to see if patient is a cosmetic/bariatric patient
        1. If patient is a cosmetic/bariatric patient, collect full payment prior to service
        2. If patient is not a cosmetic/bariatric patient go to and repeat **STEP 1-part a) -> i**
            a. If patient is not scheduled, determine if they are a direct admission
                i. If patient is not a direct admission, end process
                ii. If patient is a direct admission check patients' insurance
        3. If patient is insured leave a direct admissions letter at bedside
            a. If patient is not insured, refer to EAV.

Follow Eligibility Assistance Vendor (EAV) Referral SOP

For additional information refer to the Point of Service Collections Policy, Financial Clearance Policy and Financial Assistance Policy.

CarePricer Estimates for Patients

Patient Access is dedicated to provided cost of care estimates for its patients.

STEP 1: Patient requests an estimate via telephone, upon admission, or during discharge.

STEP 2: Patient Access will run eligibility check / verification of insurance coverage using Relay or the payer website.

STEP 3: If Patient Access confirms coverage, no further action is required.

STEP 4: If Patient Access is unable to confirm coverage and they have access to CarePricer, they will sign into CarePricer and complete the following steps:

I. Choose the option patient or estimate
II. Select action create, edit, or view
III. Search for service and add
IV. Choose patient type
V. Add patient benefits and update amounts
VI. Complete and print estimate
VII. Notate patient account

For additional information refer to CarePricer SOP.

Downtime Procedures

Downtime is defined as any time the scheduling /registration computer system is not available for registration, charging or order entry. Patient Access will be responsible to obtain all necessary information in paper format during downtime. All information and signatures required to complete registration will be obtained during downtime.

IMPORTANT: Communication is ***KEY***. If there are any questions or problems, please reach out to your leadership or IT team using Skype, phone call or text.

During downtime, Patient Registrations will be completed manually utilizing the contents in the “Downtime Box” or “Downtime Binder” located in each department at every site.

1. Access the “Downtime Box” or “Downtime Binder” located in your work area.
2. Retrieve copies of the Downtime Registration Form.
3. Complete every field on the registration form. This is important to do, as many of these fields are critical to have in order to complete reconciliation when the system comes back up. a. Patients will need to be registered with appropriate Downtime Account Numbers (Downtime Account Numbers are site specific and are included in the “Downtime Box” or “Downtime Binder” at every site).
4. Obtain Consent/Treatment from the patient using the paper Consent/Treatment Forms located in the “Downtime Box” or “Downtime Binder”.
5. If Medicare eligible, complete and attach the MSPQ form using paper MSPQ Questionnaires located in the “Downtime Box” or “Downtime Binder”.
6. Make copies of the patients' ID and Insurance Cards and attach them to the Downtime Registration Form.
7. Use Relay, WebDenis, HAP or appropriate payer websites to verify insurance information. a. Record insurance coverage information on the Downtime Registration Form.
8. Initial or sign the Downtime Registration Form.
9. Manually Print\Complete any needed arm bands, labels or face sheets.
10. Add the completed form to the appropriate area, creating a copy of these documents for reconciliation.
11. After the system is back online, Reconciliation/Recovery will be performed.

For additional information refer to your site specific downtime procedures and reference the OneMcLaren Downtime Process , Scheduling/Registration System Downtime Policy and Patient Access Downtime Procedures as needed.

For Specific Site Instructions access the Revenue Cycle Patient Access SharePoint Processes Folder.

Training Materials

Please refer to the following training user guides as a reference to the systems used at McLaren:

Insurance 101 User Guide

AHIQA User Guide

Relay Clearance User Guide

Document Revision History				
Version #	**Date of Revision**	**Page(s) Revised**	**Revision Explanation**	**Editor Name**
1	04APRIL2020		**Created by** Rebecca Burger	**Rebecca Burger**
2	06/01/2020		**Updated per meeting with Beth Zima to make changes from Regional Directors review**	**Jennifer Cordell**

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