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INSIDE

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Payers want detailed clinical info to provide authorizations

$250,000 per quarter is at stake at one hospital

"No-auth" denials result in more than $250,000 written off per quarter for outpatient claims at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE, estimates **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization.

"Payers are requiring the medical rationale behind the request, including information on what other modalities have already been tried," she says.

Payers aren't satisfied with just the diagnosis and procedure codes. They want detailed documentation on why a procedure is necessary. **Karen Watts**, LPN, CHAA, patient access specialist at Conway (SC) Medical Center, says, "An upward climb in denials has occurred, as more and more insurance companies require clinical documentation to be exact with the billing codes. If not exact, revenue is lost."

About one-third of all claims now need clinical documentation sent to avoid denials, adds Watts. "We see a total of about $2 or $3 million a month in claims that are denied," she reports.

Payers are asking for the patient's H&P, recent lab results, previous radiology summaries, and documentation showing that conservative treatment has been tried, "but we don't get enough clinical information from the doctor's office," says **Lynn Arrington**, CHAM, director of insurance verification at Texas Health Resources in Arlington.

"... WE DON'T GET ENOUGH CLINICAL INFORMATION FROM THE DOCTOR'S OFFICE."
— LYNN ARRINGTON, TEXAS HEALTH RESOURCES

Patient access employees can sometimes bypass providers' offices. "Since there is better technology today, we can access past medical records and obtain needed information ourselves," Arrington explains. Where to find clinical information in the patient's

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medical record is a key focus of employee training. "We have 16 facilities and thousands of doctors that we get clinical [information] from, and not all systems look the same," says Arrington. "Getting that together before you even call for the authorization is the key."

Conway's patient access staff called each provider's office individually to explain why clinical information is needed for claims. "We now get medical documentation a lot more efficiently," says Watts. "Sending it with the claim for review makes payment faster and smoother." Watts estimates that $500,000 in denials are avoided each month by submitting clinical documentation in a timely manner.

To decrease denials, Nemours/duPont's patient access leaders set a goal of getting more than 98% of authorizations 10 days before the requested procedure. "We have worked with our providers to utilize templates in the EMR to make sure the clinical information is noted in the impression and plan from each visit," says Adkins.

Prevent denials

The Division of Revenue Cycle Support Services at Salt Lake City, UT-based Huntsman Cancer Hospital has been focusing on reducing "controllable write-offs," says **Junko I. Fowles**, CHAA, supervisor of patient access and financial counseling. These write-offs stem from no authorization, lack of medical necessity, and non-covered services.

The department created a template for a medical necessity letter and a medication order for pre-authorization. "This reduces the time providers spend on insurance authorization," says Fowles. If patient access doesn't receive the final treatment plan until the last minute, members of the pre-auth team ask the payers to review medications patients are likely to receive on the date of service.

Here are two challenges the department sees involving clinical documentation and payer requirements:

- The history and physical report is not dictated in a timely manner, so patient access staff members have to contact the ordering physician so the chart can be updated.
- Labs aren't drawn until the day of admission, so the treatment plan cannot be determined until the date of service.

"Depending on the lab results, the physician may change the inpatient chemotherapy regimen, so a different CPT code needs to be authorized,"

EXECUTIVE SUMMARY

Payers are requiring detailed clinical documentation for authorizations, but providers' offices often don't provide the information in a timely manner to patient access. About one-third of claims require clinical documentation at Conway Medical Center, where denials total $2 million to $3 million monthly. To avoid losing revenue, do the following:

- Compare CPT codes that were done with authorizations that were obtained.
- Get clinical information together before calling for authorizations.
- If a different procedure was done, send OR notes to explain why.

explains Fowles.

The department is seeing these three trends in payer authorization requirements:

• Due to lack of clinical documentation, claims are sent for peer-to-peer review.

"This may delay treatments," says Fowles. *(See related stories on peer-to-peers and denials resulting from the wrong CPT codes being authorized, in this issue)*.

• More payers are not allowing retro authorizations for requests received after the fact.

"The only the option left is to file an appeal when the claim is denied," says Fowles. The likelihood of getting it approved, however, is "very slim," says Fowles. "Based on my experience, we have a better chance of getting a denial overturned due to medical necessity than we do for failure to obtain authorization."

• It appears that no authorization is needed because CPT codes are not on the payer's pre-authorization list, but non-covered service denials occur.

"Since claims are subject to review, some cases will be denied if the services are considered experimental or investigational for the specific diagnosis," explains Fowles. Off-label medication usage or certain types of radiation therapy are sometimes denied for this reason.

"We spend so much time figuring this out," says Fowles. To avoid claims denials, the department is implementing a standardized template for providers and pharmacists to flag a medication as off-label.

"Better communication among ordering physicians, admitting, pre-authorization, and the financial counseling team is needed to avoid denials due to not meeting medical necessity requirements," underscores Fowles.

SOURCES

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- Karen Watts, LPN, CHAA, Patient Access Specialist, Conway (SC) Medical Center. Phone: (843) 234-6673. Email: KWatts@cmc-sc.com. ■

More payers asking for peer-to-peers

Patient access needs excellent processes to respond to payer requirements for peer-to-peer review of the patient's medical records, says **Ketan Patel**, a senior manager in the healthcare provider segment of strategy and operations for New York City-based Deloitte Consulting.

"The biggest challenge around this is it requires a significant amount of time and, also, identifying the right resource to provide a timely response back to the payer," he adds.

If the payer doesn't receive the requested information, it prolongs the authorization process. This issue could result in postponement or cancellation of the procedure. **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE, says, "Often, this results in the need for a peer-to-peer conversation and/or a letter of medical necessity. Both cause extra work for the provider and the office staff."

Access staff at Nemours/duPont facilitate the peer-to-peer review between providers and the payer medical directors. "They notify our provider of the denial, obtain information around the reason for the denial, and assist providers in connecting with the medical director as required," says Adkins.

At Arlington-based Texas Health Resources, access staff sometimes avoid the peer-to-peer review by finding out what payers are missing and getting it to them quickly. "About 25% of the time, we can avoid the peer-to-peer. But some payers are very particular, and no matter what info we give them, they still want it done," says **Lynn Arrington**, CHAM, director of insurance verification.

Some doctors are resistant to taking time to do the peer-to-peer review. "We sometimes get pushback from doctors," says Arrington. "We have seen denials where the doctor's office didn't do the peer-to-peer in time." Physicians sometimes unfairly blame patient access for not obtaining the authorization. Insurance verifiers turn to the department's physician liaison for much-needed assistance.

"It really does help us out," says Arrington. "My staff can call the doctor's office, but when it's a higher-up person speaking directly to the doctor, it means a lot more."

SOURCE

- Ketan Patel, Strategy and Operations, Deloitte Consulting, New York City. Email: ketanvpatel@deloitte.com. ■

Different CPT done than was authorized? Payers refuse to pay the claim

Are all the required authorizations in place for a procedure? Meeting this requirement doesn't mean much if a different procedure is done.

"It is difficult to predict what the physician will do once the patient is in the room," explains **Ketan Patel**, a senior manager in the healthcare provider segment of strategy and operations for New York City-based Deloitte Consulting. "This requires significant clinical documentation post-service to prove necessity and overturn denials."

Some claims denials stem from incorrect CPT codes given by providers. At Arlington-based Texas Health Resources, this problem was cropping up with radiology services, says **Lynn Arrington**, CHAM, director of insurance verification. "We give that information back to the hospital, who then communicates it to the radiology department," she says. "Since they know the cause of the denial, everybody is on the same page about what we need to do."

Insurance verifiers then call the payer to see if the CPT code can be changed. "Our denials on [radiology] have gone down, but for heart procedures, denials have gone up," says Arrington. "The doctor's office is scheduling one CPT code, but it really should have been something else."

The patient access department at Wilmington, DE-based Nemours/Alfred I. duPont Hospital for Children is focused on decreasing "no-auth" denials due to a miscommunication of the proposed procedure or a change in codes performed from the codes authorized. "We continue to work on a process for catching code changes post-procedure," says **Lisa Adkins**, MSN, RN, CPNP, CRCR, director of patient authorization.

Alerting payers of the discrepancy isn't any guarantee the claim will be paid. "Many payers have very strict timelines for resubmission of 'changed/additional' codes that were not authorized prior to the procedure," Adkins explains.

Here are two common examples of discrepancies that cause claims denials:

• Precertification is obtained for a CT scan with contrast, but one without contrast is performed, or vice versa.

In these cases, says **Karen Watts**, LPN, CHAA, patient access specialist at Conway (SC) Medical Center, "most insurance will not pay." To avoid this, patient access makes sure the hard copy precertification from the insurance company matches the physician's orders.

• A procedure was done in the OR in addition to what originally was authorized.

"In some cases, sending OR notes to explain why another procedure had to be done can prevent the denial," says Watts.

Patient access now obtain the physician's orders via electronic fax at the time of scheduling. "We also ask that if authorization had to be obtained prior to scheduling the procedure, to fax us a copy of that with the orders," says Watts. Patient access staff compare the CPT codes on the authorization documented with the insurance company with the physician's order. "If authorization has to be obtained, we ask that it be sent as soon as possible so we have time to compare the two hard copies," says Watts. "If we do not have a hard copy of the authorization, we recover it online or through a phone call to the precertification company."

If patient access staff members spot a discrepancy, they take immediate action. "We call the physician's office to clarify what the doctor wanted versus what CPT code was pre-certed," says Watts. The physician's office then can modify the authorization, or the physician can modify the order.

"This almost always avoids a denial," says Watts. "Of course, there are times that no matter how much information is sent to the payer, they still do not pay." ■

Foolproof ways to move up quickly in access

Having started out in an entry-level position in patient access helps **Kim Rice**, director of patient access at Redding, CA-based Shasta Regional Medical Center, to advocate for her staff.

"I know what they face in their roles and can be their voice," she says.

Rice advanced from a clerk to a manager and then to a director. Her first step was to go back to college and obtain an associate's and bachelor's degree in health and human services. "I am currently finishing a graduate program to obtain a master's in health administration at the University of Phoenix," she reports.

Having patient access and

business office experience helped Rice to advance. "Understanding the revenue cycle and the departments involved allows me to recognize the importance of each of these areas," she says.

See "the bigger picture"

Kaylyn Lambert, a patient access manager at OSF Saint Elizabeth Medical Center in Ottawa, IL, constantly asked for more responsibilities to obtain her current position.

"On-the-job learning is crucial to move up within the revenue cycle and patient access fields," she emphasizes.

Rice recommends participating on your hospital's Health Insurance Portability and Accountability Act (HIPAA) committee. "Patient access staff work in an area that has high potential for HIPAA violations," she explains. "Staff collect patient demographic and insurance information that has room for errors to take place."

Molly Hinderliter, CHAA, a supervisor in patient financial navigation at Indiana University Health West Hospital in Indianapolis, began her patient access career as a temp. "From day one, I expressed interest in a leadership position," she says. "At my 30-day review, I asked what I could do to develop myself to be ready for an opportunity when it presented itself."

Hinderliter's manager challenged her to become an expert in her area and to learn as much as she possibly could. "They kept asking for volunteers, and I kept signing up," she says. "They gave me tasks that brought me out of my comfort zone and helped me grow as a team member."

Hinderliter interviewed for supervisory positions three times unsuccessfully, but she was undaunted. Each time, she asked for feedback on how she could do better. "It was a matter of getting more experience overall," she says. "I reached out for opportunities to do more things."

Hinderliter represented her department at hospitalwide Ebola preparedness training events. "I was also asked to sit in once every two weeks on our 'report out' that is done for our registration numbers," she says. "This enabled me to see the bigger picture."

Hinderliter peppered the meeting's presenter with questions on registration so she could fully understand how the process worked. Soon after, she obtained her certified healthcare access associate (CHAA) credential. "I knew this would force me to learn as much as possible about registration and be an asset to the team," she says. *(For more information on CHAA certification, see "12 registrars in this system CHAA-certified each year,"* Hospital Access Management, *June 2013.)*

Teri Cheeks-Rice, CHAM, performance coordinator of the revenue cycle education department at Indiana University Health in Indianapolis, started out as a registrar, advanced to a supervisor, and transitioned into an educator. She is now the National Association of Healthcare Access Management's education chair. "I have been in the patient access field for my entire adult life," she says.

Cheeks-Rice credits her success in large part to a mentor who was passionate about patient access. "She made sure that we never felt as if we were 'just registrars,'" she says. "She worked hard to ensure our understanding of the revenue cycle and the role we played."

Cheeks-Rice says employees should "get involved in all things patient access." Here are her recommendations:

• Subscribe to area insurance emails, such as local Medicaid alerts.

"Patients expect that a registrar knows everything about the insurance card they present," says Cheeks-Rice.

• Get involved in your department's denial reviews.

"Find out what causes a denial, and educate others," says Cheeks-Rice. "This helps others with their accuracy rate, as well as reducing denials for your organization." For example, registrars can alert peers if a local Medicaid plan denied a claim because the patient had another health plan that should have been the primary.

• Take part in preparing for National Healthcare Access Personnel week.

"Sign up to help organize some of the weeklong festivities for your department," suggests Cheeks-Rice.

EXECUTIVE SUMMARY

Expanding your knowledge to all areas of the revenue cycle, and even healthcare in general, is the key to advancement in the field of patient access, according to leaders interviewed by *Hospital Access Management*. Some proven strategies:

- Get to know colleagues in the business office and medical records.
- Represent the department on hospital committees.
- Network with patient access managers at other facilities.

(NAHAM's Access Week toolkit is available at http://bit.ly/1fs39UJ. For more information, see "Healthcare Access Personnel Week offers opportunity to celebrate with your staff," Hospital Access Management, *April 2015.)*

• Spend time shadowing staff members in health information management and patient financial services.

"See how the revenue cycle works, how patient access affects everything they do, and where your role as a registrar fits in," says Cheeks-Rice. *(See related story on networking in patient access, in this issue.)*

SOURCES

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Novel ways you can network

In the field of patient access, "you can never network too much," says **Kaylyn Lambert**, a patient access manager at OSF Saint Elizabeth Medical Center in Ottawa, IL. "It's never too late to build those relationships, no matter how early or how far you might be in your career."

Attending national conferences might not be possible for an entry-level registrar. **Kim Rice**, director of patient access at Redding, CA-based Shasta Regional Medical Center, says, "Networking can sometimes be challenging if you are not in a position to get out and meet others." Here are some low-cost ways to network:

• Participate in conference calls.

"This provides the opportunity to meet others outside of your geographical location and build a relationship," says Rice.

Registrars could participate in conference calls with vendors about technology being considered by the department, for example. "Frontline staff would have the best questions to ask and will know if the product will suit their needs for improved tools," says Rice.

• Reach out to patient access managers at other facilities.

"Even if you are from different hospitals, if you are in the same town or state, you — more than likely — are experiencing the same challenges," says Rice.

Rice often problem solves with a network of patient access managers at other facilities. "I shoot out emails to get a general response from all of them, which can help drive improvements," she says. A recent question involved how to prevent staff from accidentally grabbing more than one patient packet from the printer and inadvertently giving information to the wrong patient.

> IN THE FIELD OF PATIENT ACCESS, "YOU CAN NEVER NETWORK TOO MUCH."

"Several other facilities suggested adding a page break between patient packets after they're printed, to separate the different patient packets," says Rice.

• Get to know others in the organization.

"Get to know the medical records team, the business office staff, and anyone else that will speak about the great work you have helped with," advises Rice.

By taking the time to introduce yourself, you'll have a personal connection if an issue requires you to interact with someone from that department. **Teri Cheeks-Rice**, CHAM, performance coordinator of the revenue cycle education department at Indiana University Health in Indianapolis, says, "In the patient access arena, we interact with people from many different departments. Patients often hear our conversations and are placed at ease when our communications are relaxed."

• Online networking.

Lambert says, "LinkedIn is a wonderful tool to use, not only for networking, but also to build knowledge of the industry and for job searching." *(Join our LinkedIn group, Hospital Access Management, to network with your peers and be the first to know the latest news and announcements in the patient access field.)* ■

Emails are too slow — Here are new ways to communicate with patient access staff

Is an irate patient demanding to speak with a supervisor? Does a registrar need to leave immediately because of a family emergency?

When you need a quick response from employees, or they need one from you, playing phone tag or waiting for a response to an email isn't the best option.

"We have made several changes, with the age of cell phones and texting and staff being of younger age," says **Linda Boehm**, supervisor of patient access at Genesis Medical Center, Silvis (IL) and Genesis Medical Center Aledo (IL). Here are some ways patient access managers are speeding communication with employees:

• Instant messaging.

Boehm and her colleagues use this communication method whenever they want quick responses, such as:

— checking to see if others are having problems with a certain system, indicating that the system is down;

— asking others about an insurance they haven't seen before;

— finding out if anyone called in sick over the weekend, so unscheduled paid time off can be added to payroll.

"We can be in a meeting or on a conference call, and it pops right up on the screen," says Boehm. "Staff can tell if we are logged in or away from the computer."

• Texts, sent by managers to alert staff if a registrar calls in sick.

Texts are sent out to employees and per diem staff stating the hours available and who to contact if they can pick up all or part of the shift. "This is especially good when someone calls in late at night for an early shift," says Boehm. "We have an email group set up and shared with those who work the night shift, so they can send it out."

Not all employees signed up to receive the texts, but most have. "It saves us supervisors hours of time by not having to get on the phone and start calling everyone individually," says Boehm. "Most staff will answer a text before they will answer a phone call."

> "WE HAVE MADE SEVERAL CHANGES, WITH THE AGE OF CELL PHONES AND TEXTING AND STAFF BEING OF YOUNGER AGE."

Sometimes staff respond that they're willing to come in if the manager can't find anyone else. "I have had staff call in within five minutes of the text going out to say they can help cover," says Boehm.

Updated texts alert registrars once someone has picked up any of the available hours. "This lets them know the department may be short only for a couple of hours, not the entire shift," says Boehm. "Staff is pretty good at picking up part of shifts. They will stay over or come in early."

• Texts, sent by employees to supervisors.

Savannah Green, patient access manager at Newberry (SC) County Memorial Hospital, says, "More staff members are communicating with me via text. They can easily reach me with questions on new procedures."

One downside is that patient access managers end up responding to texts after work. Green suggests designating a shift leader to answer staff questions during off hours. "Unfortunately, when you are accessible almost 24/7, it is sometimes hard to disconnect from work while you're at home," says Green.

SOURCES

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EXECUTIVE SUMMARY

Patient access managers are increasingly using texts and instant messaging to communicate with each other and their employees.

- Texts can alert employees of a shift that needs to be filled.
- Managers can obtain instant answers to questions.
- Staff members are more likely to respond to a text than a phone call.

Four hours a day is too much time on the phone with payers — Hold times last up to 45 minutes

Financial counselors at Stonybrook (NY) University Medical Center spend about four hours a day on the phone with insurance companies verifying inpatient benefits and obtaining authorizations.

"The calls are very time-consuming," says **Christine Downey**, supervisor of financial services. "We are often on hold for an extended length of time." Her staff members spend up to 45 minutes on hold, and they spend another 20 minutes getting the needed information.

At OSF Healthcare System's Financial Clearance Center in Peoria, IL, "hold times for some payers are 30 minutes," says **Jessica Chase**, patient access services manager. Sometimes, patient access staff members find out that an authorization never was initiated. "This prompts us to reach out to ordering providers," Chase says.

Often, employees need to call payers just to verify the receipt of a fax informing the payer that a patient was admitted. **Doris Fehrenbach**, MS, Stonybrook Medicine's manager of financial services, says, "Some insurance companies do not acknowledge that fax." First, employees look for the precertification number on the payer's website, which indicates that the fax was received. "If it is not there, we have to call," says Fehrenbach.

Payers also need to be called if a patient is admitted and discharged over the weekend. "Insurance companies refuse to give a precertification even though a fax notification was sent, because the patient is discharged," says Fehrenbach.

Payer sites are limited

To avoid getting stuck on the phone for hours, Stonybrook's patient access staff obtain information online whenever possible. "I have never really calculated how much time we save. But it is better than waiting on the telephone," says Downey.

However, some payer web sites don't post authorization requirements. "Depending on the web site and the test or procedure, we may be able to get the information needed to effectively document the authorization information," says Chase. Whether they can do that sometimes depends on whether the necessary clinical documentation has been submitted for the authorization to be initiated.

"Phone calls to payers are often needed to verify benefit information that isn't provided on the web site," adds Chase. "Some web sites are more thorough than others." If pertinent information is missing from the web site, patient access staff members have no choice but to call the payers.

Highly specialized services provided by the tertiary care facility often are not clearly delineated on the payer web site, says **Debra Menaker**, MPA, senior director of revenue cycle operations at NYU Langone Medical Center in New York City. "As payers add services that require authorization, insurance clearance representatives are required to spend more time calling payers to obtain this information prior to service," Menaker adds.

Insurance clearance representatives at NYU Langone call payer representatives for these reasons:

- to confirm if an authorization is required;
- to obtain an authorization;
- to follow up on an authorization request;
- to verify out-of-pocket liabilities for an outpatient hospital facility visit.

"It remains difficult to reduce the time spent on the phone," says Menaker. To save time, the department groups accounts by payer and/or type of service. With this method, staff members obtain multiple authorizations with one phone call.

"The amount of time spent on hold and speaking with payer representatives could be reduced if online portals were enhanced with more detailed benefit and authorization information," notes

EXECUTIVE SUMMARY

Patient access employees often have to make time-consuming phone calls to payers to obtain authorization or inform payers of a patient's admission.

- Some calls can be avoided by obtaining authorization and verifying benefits online.
- Requests can be grouped by service or payer so multiple authorizations can be obtained in a single call.
- Payer sites often lack a comprehensive listing of CPT codes and related authorization requirements.

Menaker.

For example, many payers don't provide a comprehensive listing of CPT codes and related authorization requirements online. "This would be a simple way to reduce calls," says Menaker. "A more robust online portal could offer authorization submissions and responses."

SOURCES

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Satisfy patients — Don't disparage clinical areas

Have registrars compliment other hospital departments

"Oh, radiology is just terrible. They're always running behind!" If patients hear this disparaging comment from a registrar, patient satisfaction suffers for the clinical area *and* patient access.

"The patient's entire experience rests on how well we communicate and support one another," emphasizes **Karen Garrison**, patient access manager at Bronson Methodist Hospital in Kalamazoo, MI.

At Eisenhower Medical Center in Rancho Mirage, CA, patients often call the front desk because their prescriptions have not been called in, because they're unable to get in to see their primary care physicians, or because they've waited days for a call back from a clinical area, says physician referral coordinator **Tracey Thole**. "The access department often hear complaints they feel should be directed to the clinical team," she explains.

Bronson Methodist's patients are instructed to come back to a registration staff member if they wait more than 15 minutes past their scheduled appointment times. When a patient comes back to registration, says Garrison, "it would be very easy to blame the area performing the test for not staying on time for their patients."

Instead, registrars apologize for the wait, follow up with the department, and find out when someone will be out to greet the patient. "We find patients are understanding. They appreciate that they haven't been forgotten," says Garrison.

Registrars at Spartanburg (SC) Regional Healthcare System make a point of "managing up" the clinical departments they send patients to. "If we lift our co-workers up, they will, in turn, do the same for us. That provides excellent customer service all around," says **Jordan Martin**, corporate educator for patient access services.

For example, if a registrar walks a patient to a testing area, he or she might say, "Mrs. Smith, this is Cindy. She is going to be your CT technologist. Cindy has been here for a long time and is going to take great care of you." Likewise, a registrar might say, "Mrs. Smith, I see Dr. Simon is your physician. He is excellent. He is very good at listening and answering patient questions. You will be pleased with the care you receive from Dr. Simon."

"If we notice a patient is waiting for longer than 10 minutes to be called back, we always call and check with the department," says Martin. The registrar tells the patient that he or she is doing so by stating, "My name is Jordan. I registered you about 10 minutes ago and noticed you are still waiting. I checked with the lab, and they should calling your name soon."

Alleviate anxiety

Simple facts often calm patients who are anxious about the procedure they are about to have.

"This occurs mostly with our CT and MRI patients, who have heard multiple horror stories from their friends or family members," says Martin.

EXECUTIVE SUMMARY

Patient access employees might be tempted to blame clinical areas for delays or long waits, but this blame can have a negative impact on overall patient satisfaction. Instead, registrars can do the following:

- Follow up with the clinical area on the patient's behalf if there is a delay.
- Compliment individual clinicians whom the patient will see next.
- Alleviate anxiety about diagnostic procedures.

Some MRI patients stated how scared they were to be completely closed up in the machine prior to their test.

"I explained to them that the machine isn't closed and at no point are they going to be trapped in the machine," says Martin. Martin also lets patients know they'll hold a button in their hand that alerts the technician if there is a problem.

"We take pride in the fact that we know and are familiar with all of the diagnostic areas that we provide service for," says Martin. Patient access employees tell patients how long a procedure should take and give them an idea of what to expect. "The amount of time that each test takes is built into our schedule," says Martin. "If the patient is here for an MRI of the brain, for example, we can tell them that this test should take anywhere from 20 to 30 minutes." *(For more information, see story on shadowing clinical areas in this issue.)*

SOURCES

- Karen Garrison, Patient Access Manager, Bronson Methodist Hospital, Kalamazoo, MI. Email: garrisok@bronsonhg.org.
- Jordan Martin, Patient Access Services, Spartanburg (SC) Regional Healthcare System. Phone: (864) 560-6238. Email: jemartin@srhs.com.
- Tracey Thole, Physician Referral Coordinator, Eisenhower Medical Center, Rancho Mirage, CA. Email: tthole@emc.org. ■

Put patient access staff members in clinical areas

Patient access staff members should shadow employees in the clinical departments they schedule for, suggests **Tracey Thole**, physician referral coordinator at Eisenhower Medical Center in Rancho Mirage, CA. "Almost all issues that arise are due to lack of communication," Thole says. "All departments need to work as a team."

At Arnold Palmer Medical Center in Orlando, FL, managers place patient access representatives in clinical settings. "We've moved to a more collaborative approach. Each of us plays an important role in providing an exceptional customer experience," says **Mary Ellen Daley**, MHA, CHAM, CRCR, manager of patient business.

The department created an access specialist role. "They are placed in physician practices where there is a hospital-based service," says Daley. For example, in the pulmonary and gastrointestinal offices, access specialists handle registration, scheduling, insurance verification, and authorizations.

"We also have patient access team members working in outpatient clinics throughout the hospital," adds Daley. "As part of their orientation, they observe the clinical flow."

Patient access employees learn the complexities of patient care, and clinicians learn what is required to ensure services are reimbursed. "As the culture has evolved, patient access leadership has been invited to attend clinical staff meetings. Clinical leadership may attend patient access meetings and huddles," says Daley.

The collaborative approach prevents claim denials. "We are at the point of service and have access to physicians and other clinicians to obtain required clinical documentation," explains Daley.

SOURCE

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Automated calls cut no-show rates to 0%

Up to one-quarter of patients cancel or reschedule

An automated reminder system has reduced the no-show rate in behavioral health by 20% at Western Connecticut Health Network, reports **Maureen Moreno**, MBA, director of patient access and the Contact Center at Danbury (CT) Hospital.

"We make three attempts at different times over two days," says Moreno. The first call is made at 6:30 p.m., the second call is made during the late morning the following day, and a third call is made during the afternoon. "If someone answers the phone or it hits voicemail, there are no more attempts," Moreno says. If the patient answers, the recording states the patient's first name, address, and appointment time. The patient can confirm the appointment, speak to a representative to reschedule, or cancel.

"That call then goes directly to a scheduler," says Moreno.

Because preregistration is now centralized with the Patient Access Contact Center, all patients in the

health system's three hospitals receive the same automated reminder calls. "Before, it was all decentralized, so there was no rhyme or reason," says Moreno. "Some departments were calling the patient to remind them of appointments, and some weren't."

Reducing no-shows increases productivity. "If the patient doesn't show up, then that technician is idle, so there is a loss," explains Moreno. Patients make some follow-up appointments six months in advance and simply forget about them. Using the new system, "we've found it a win-win. Either the patient can reschedule, or the patient will show up," Moreno says.

The automated tool allows managers to track no-show rates and how patients responded to the reminder calls.

"Because processes were inconsistent before, we never had any way to track it," says Moreno. "Since we've been doing this for some time, we've seen some trends." When the weather is bad, patients typically call to reschedule appointments; when the weather is nice, though, many patients just don't show up.

Patient access staff members need permission to call a patient's cell phone, notes Moreno. "We get them to grant permission by asking the patients if we can use their cell phones and noting the account. We are close to 50% of cell phone numbers as a main contact," she says.

Some patients comment, "My doctor sends me text messages. Why can't you?" "We don't do text currently, but it's definitely something that patients want," says Moreno.

Patients sometimes indicate that they don't want or need the reminder calls. While some behavioral health patients need reminders because they repeatedly fail to show up for monthly appointments, others want to be removed from the call list. "Some patients have come in multiple times a month for years, and they don't need a reminder," says Moreno. "We work with departments, and we tweak things." *(Western Connecticut Health Network uses TeleVox House Calls, manufactured by Mobile, AL-based TeleVox Software.)*

EXECUTIVE SUMMARY

Patient access/registration/scheduling areas are using automated reminder calls to reduce no-shows. No-shows in behavioral health were cut by 20% at Western Connecticut Health Network. Some practices at Orlando Health now have 0% no-show rates.

- Patients can speak directly with a scheduler to cancel or reschedule the appointment.
- Patients are likely to forget appointments made months in advance.
- Managers track no-show rates and how patients responded to the reminder calls.

0% no-show rate

At Orlando (FL) Health, front office assistants use an automated tool to ensure all available slots are used.

"Previously, practices would have to make these calls manually, often reaching a lot of answering machines because calls were made during regular business hours," reports **Tawnya Adkisson**, corporate director of population health and care coordination.

Automated calls now are made in the evening, when patients are more likely to be available to respond. "This means a greater response rate, which leads to more appointments confirmed," says Adkisson. Staff members are alerted of cancellations far enough in advance to book another patient in the now-available timeslot.

"Because we are able to act so timely, our current no-show rate across all practices is 5%," says Adkisson. "Some practices actually have a 0% no-show rate."

Automated calls have been made to nearly 750,000 patients to date. "Depending on the department, as many as 25% request to cancel or reschedule their appointments," reports Adkisson.

If the system reaches a person instead of an answering machine or voicemail, the patient is prompted to select what he or she intends to do with that appointment: confirm, reschedule, or cancel.

"The system then collects information regarding the patient's intention and displays it back for us in real time," says Adkisson. "We act on any cancel or reschedule requests." *(Orlando Health uses Phytel Remind, manufactured by Dallas-based Phytel.)*

COMING IN FUTURE MONTHS

- Make staff experts at explaining patients' out-of-pocket costs
- Avoid bad publicity on your collection practices
- Essential metrics to add to patient access job descriptions
- Patient portals can dramatically increase revenue

SOURCES

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Hospitals join hotels in receiving reviews on Yelp

The newest addition on the Yelp web site is reviews of hospitals, nursing homes, and doctors.

Yelp has teamed up to do the reviews with ProPublica, an independent, non-profit newsroom that provides investigative journalism. Yelp will post information from ProPublica's interactive health databases on its health provider pages. The information offered is consumers' experiences, including average wait times. The data come from the Centers for Medicare and Medicaid Services.

These reviews put hospitals in a position to learn a lesson hotels and restaurants picked up a long time ago: Customer service matters, perhaps more than anything else. ProPublica reports that when people are unhappy about their service, they complain. But the good news is that most patients are happy. There are many more five-star ratings than one-star ones among healthcare providers. Four stars is the average.

Focus on the areas patients are likely to complain about: long wait times, difficulty getting an appointment, billing errors, and customer service, according to the blog @HospitalReport, published by AHC Media, which also publishes *Hospital Access Management*. *(For more information on this topic, see "Want satisfaction scores to soar? Simple solutions give big results," HAM, August 2015.)* ■

HHS issues county data on Marketplace plan selections

The Department of Health and Human Services has issued county-level data on 2015 open enrollment in qualified health plans in the states that use the HealthCare.gov platform for their Health Insurance Marketplace.

The data include total plan selections by metal level, consumer type (new, auto re-enrollment, or active re-enrollment), family income, race/ethnicity, age category, advanced premium tax credit, and cost-sharing reduction. The states include: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, and Wyoming. To access the data, go to http://1.usa.gov/1JBdicj. ■

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