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INSIDE

RELIAS MEDIA

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Well-Trained Registrar Can Protect Hospital From EMTALA Violations

A man out shopping with his family began experiencing chest pain, and went straight to the nearest ED. At registration, the man asked if the hospital participated in his health plan. The answer was no, but the registrar urged him to stay for evaluation anyway.

The man left the ED to go to a hospital that took his insurance, just 10 minutes away. On the way, the man suffered a heart attack and died. The family sued the hospital for medical malpractice and violation of the Emergency Medical Treatment and Labor Act (EMTALA).

"The registrar's good training and routine practice actually helped to protect the hospital," says **Mary C. Malone**, JD, a partner at Hancock Daniel in Richmond, VA. During depositions, the man's adult son testified that the registrar had stated two things:

- His father had a right to treatment, regardless of his insurance, under federal law;
- He should not leave the ED until he saw a physician.

"Despite these warnings, the man and his family had decided to leave, but only after having been informed of his rights to treatment under EMTALA," Malone notes.

The malpractice lawsuit was settled out of court, but the plaintiff attorney dropped the EMTALA claim. "The defense attorney believed it was because of the son's deposition testimony that the registrar informed them of EMTALA rights, and discouraged them from leaving," Malone says.

Many people, understandably, want to know if their ED visit is going to be covered by their health insurance. The registrar's remarks, however well-intentioned, can be construed as an EMTALA violation. "Registrars can get into trouble if they are not trained on how to respond to payment questions," Malone warns.

If the registrar tells a patient she should go to a nearby urgent care center instead of the ED specifically because her coverage is out of network, that is a possible EMTALA violation. To a CMS investigator, it might look like the patient was discouraged from staying for insurance reasons.

Malone says registrars need to clearly communicate that the patient has a right to a medical screening examination (and, if necessary, stabilizing treatment) regardless of ability to pay. "Access to emergency services, without regard to ability to pay for those services, is at the very core of the EMTALA law," Malone says.

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CMS also will not look kindly on copay collections that interfere with patient care in any way. "Any kind of practice where screening or treatment is delayed or not provided, in connection with the hospital seeking financial information regarding the patient's ability to pay," can mean big trouble for hospitals, Malone says.

If the patient decides to leave the ED, worried about a huge bill, and has any kind of bad outcome, an EMTALA complaint is possible. A signed against medical advice (AMA) form is one way of demonstrating that the person was aware of their rights under EMTALA. Of course, not all patients will agree to sign such forms. But if the patient has at least provided a name, the form still can be completed, Malone says. The registrar would indicate on the signature line that the patient was provided the EMTALA notice but refused to sign the form. "Such forms should be maintained in case they need to be shown during a survey," Malone adds.

Timothy C. Gutwald, JD, a healthcare attorney in the Grand Rapids, MI, office of Miller Johnson, says these are the two riskiest practices for ED registrars:

- Delaying treatment in any way to obtain insurance information or preauthorization;
- Giving the impression that the ability to pay or valid insurance coverage is required to receive treatment.

Whenever an ED patient asks about financial liability related to emergency medical treatment, registrars should direct them to an appropriate person. Whoever answers this very important question, says Gutwald, "should make it clear to the patient that, regardless of the patient's ability to pay, the hospital will provide a medical screening examination and stabilizing treatment, if necessary."

Too many registrars have a dangerous misconception. They believe the moment a medical screening exam is complete that it is totally fine to demand payment. This is not necessarily the case.

"ED registrars should never be collecting a copay or deductible before the patient has had a medical screening examination and is stabilized," says **Sue Dill Calloway**, RN, MSN, JD, a Dublin-OH based nurse attorney and president of Patient Safety and Healthcare Consulting and Education.

The Office of Inspector General has fined many hospitals for this. "The penalties have significantly increased, so this should be on the radar screen of all hospitals," Dill Calloway offers. "This is a hot area where they are going to throw the book at you." CMS has made it clear that if registrars ask for payment or insurance information before the medical screening examination and stabilizing treatment are complete, hospitals may face the maximum fines.

What if a medical screening examination has been completed already and shows the patient does not have an emergency medical condition necessitating stabilizing treatment? Some patients will wonder if it is worth staying and what they are going to owe. "It is appropriate to have a good patient financial counselor available to address the patient's questions and concerns," Gutwald says.

Gutwald cautions that CMS has been "very clear" that hospitals and EDs need to be careful when discussing financial issues with patients before they receive stabilizing treatment. "Patients leaving before receiving a medical screening examination and stabilizing treatment is a big concern for the government," Gutwald says.

Hospitals and EDs should try to defer these conversations until after the medical screening examination and

any necessary stabilizing treatment have been performed. "If patients repeatedly leave prior to a medical screening examination or stabilizing treatment, hospitals and EDs should re-evaluate how they are handling these questions and consider retraining staff," Gutwald adds.

Gutwald says CMS investigators may view these practices as discouraging people from seeking necessary treatment in the ED:

- Requiring patients to complete financial responsibility forms;
- Seeking preauthorization or contacting a managed care company prior to the initiation of stabilizing treatment.

"CMS has advised that best practice is to not give financial responsibility forms, notices, or obtain patient agreements to pay services until after stabilization treatment has begun," Gutwald explains. If registrars do not realize stabilization treatment is needed, they may ask for a high-dollar amount before it is completed. This is "very problematic," Gutwald adds.

As long as patients are provided a medical screening examination and any necessary stabilizing treatment without a payment-related delay, asking for high-dollar amounts probably will not violate EMTALA. However, it is a problem if a hospital's policy or practice results in patients leaving during the course of treatment or deters patients from seeking treatment. "CMS may conclude the policies are not reasonable and violate EMTALA," Gutwald explains.

Recently, Dill Calloway visited an ED with suspected pneumonia. Right after triage, she was asked for a $500 copay. The registrar seemed to have no understanding of EMTALA, even after being warned copay collection prior to a completed medical screening examination was a violation of federal law. "When I got better, I talked to the hospital risk manager," Dill Calloway says. "The CFOs can get hospitals in trouble with EMTALA."

The incident spotlights the need to educate ED registrars on what they can and cannot do regarding collection.

"Now that fines have more than doubled, people really need to pay attention to this," Dill Calloway stresses. "The penalties are huge."

It is a difficult balancing act for revenue cycle staff. "Hospitals need to be paid for the services they provide," Malone acknowledges. Once patients leave the ED and go home, it is well-known that the odds of the hospital receiving any payment at all plummet. However, says Malone, "the consequences of a payment-related EMTALA violation are much higher than not getting paid for every ED visit." ■

Collection Goal: Half of Potential Outpatient Dollars

At Albany (NY) Medical Center, a bedside point-of-service collections initiative in the ED began in 2018. It started rocky. "We started with incentives for staff," says **Karen Gardner**, manager of access services for the ED. Registrars who agreed to collect were given longer lunch breaks or were allowed to pick their daily assignments, such as bedside registration or answering incoming calls.

This worked well — for a few months. Soon, the department found that the incentives "become a nightmare to manage," Gardner laments. "We had all staff collecting, which was great." But providing 45-minute lunches for up to 14 people per shift proved impossible to maintain. The incentives were taken away, and it did not take long for collections to plunge to near zero. "Our mistake was not having a plan in place to hold staff accountable," Gardner reports.

A few months later, the department set a new collection goal of 50% of potential outpatient dollars. At the time, registrars were collecting anywhere from 19% to 24% of this amount. "We needed to find a way to hold staff accountable, in real time, to the goal," Gardner says.

First, leaders tried to motivate staff by keeping them in the loop on how the department was performing overall. Each week, staff received a report detailing the dollar amount that was collected compared to the potential amount that could have been collected. The report also tracked registrar mistakes. These included insurance errors, eligibility errors, third-party liability errors, and amount-owed errors. Managers noticed some mistakes in Coordination of Benefits rules, which apply when someone presents with both Medicare and another kind of insurance.

A common mistake is incorrectly billing Medicare as the primary insurance instead of an HMO. In some cases, a patient's amount owed was incorrectly listed as zero. This meant that no one collected at the bedside. Also, the copay collection letter was not sent the next day since it appeared the patient owed nothing. "When we reviewed the encounter on the next day, we would provide education on reading our eligibility response," Gardner says.

Sometimes, staff struggled to determine what the patient owed. Also, they were unclear as to whether there was third-party liability.

To clear up confusion, staff were divided into groups, led by one of four supervisors. Each newly hired employee is placed in an "onboarding" group for the first six months. The others are assigned based on their primary shift, with groups ranging from six to 11 employees. Each supervisor was charged with educating the entire group on common errors, the Coordination of Benefits rules, how to determine the patient's financial responsibility, and encouraging staff to collect bedside.

"Our previous collection process was waiting for patients to present to an office after services were completed," Gardner says. This was not very effective.

Scripting, role-playing, and observation were used. "Getting over their fear of asking for money was the biggest hurdle," Gardner recalls.

Equipment was another frustrating obstacle. "Our wireless credit card machines are not the most reliable," Gardner says. The IT and cash management teams are working on the problem. For now, staff use a wired credit card machine, which is not ideal because payments cannot be processed in-room.

Staff were emailed the metric on the department's performance every week. "There was little improvement," Gardner says. Things changed quickly when the department started publicly posting the same information, but this time about individual staff members. Every registrar's status on how much they collected and how this compared to the potential that could have been collected is posted by color. Employees who collect from 0% to 15% get a red card, 16% to 35% get orange, 36% to 49% get yellow, and more than 50% get green.

Currently, the department has almost reached its target. "We are running at 48% of potential dollars collected for the pediatric and adult EDs," Gardner reports. "Staff are responding to peer-to-peer competition."

For now, at least, patient access is not planning any changes to this successful process. Every Tuesday, associates are called out on the collection board if they improve from where they were the week before, or if they reach the level of green. Staff members stuck at the "red" level are asked what is keeping them from collecting. Associates who improved enough to change to a higher color level are asked how they did it. Any associate who earns four green ratings in a calendar month receives a gift card and praise at a staff meeting. "It has been a very dynamic and engaging process for the team," Gardner says.

Albany Medical Center's registrars have experienced success collecting, but they do so with caution. All receive extensive EMTALA training, starting at their orientation. Skills are reviewed annually.

To avoid EMTALA issues, an attending physician at the ED's walk-in entrance screens patients almost immediately. Once EMTALA requirements are met, staff complete the registration and request payment. This is the script: *"You have a ($$) financial responsibility for today's services. We accept credit card, cash, or check. How will you be paying for your services today?"*

"Associates are trained to be direct and confident in their words," Gardner says. "Consistency brings hardwired behavior, and patients respond to that." Registrars are instructed not to demand payment or threaten to withhold services if someone cannot pay. Patients rarely leave the ED due to concerns about their financial obligations, Gardner notes. "If a patient gives any indication that they may leave because of an inability to pay at the time of service, we explain they have options."

Registrars explain that partial payments are accepted, or a copay letter can be mailed the next day. Patients can call the department to make a payment, or they can be billed later. "We can also direct them to our patient assistance unit for financial aid screening," Gardner says. ■

Patients Eager for Financial Information, But Registrars Must Be Careful

ED registrars should never discuss or ask for payment prior to meeting EMTALA requirements, says **Maureen Bottom**, patient access director at Texas Health Resources.

"In no way do we want to interfere with emergency or stabilizing medical care, or give a perception that ability to pay comes before their health," Bottom says.

The hospital's EHR tells registrars when it is OK to obtain consents and educate the patient about insurance coverage findings. Avoiding finances entirely is not realistic and is in no one's best interest, Bottom says. The hospital needs payment, and patients want to avoid surprise bills. "Surprise billing is a hot topic for consumers, so *not* talking about insurance benefits can be a bigger problem," Bottom notes.

Many patients have heard horror stories about astronomical bills for ED visits. Some patients arrive already worried about what insurance will cover and bring up the topic themselves. "Patients absolutely want to know," Bottom says. An unexpected, confusing hospital bill coming weeks or months after the ED visit devastates patient satisfaction scores. "It sometimes sours the patient's overall experience, even when the healthcare experience is exceptional," Bottom says.

Patients have a right to make choices on where they receive care. However, as a Level II Trauma Center, Texas Health Fort Worth receives some patients with needs that cannot be met anywhere elsewhere in the community. Giving people the information they need to make informed financial decisions, while encouraging them to get care they really need, is quite a balancing act.

"[Registrars] work hard to share any pertinent information when the situation is right," Bottom says. "But at the same time, we always respect the healthcare needs of the patient."

"Is this hospital in network with my insurance?" This is one of the most common questions people ask ED registrars.

"Helping the patient understand what this means and how it impacts them is critical," Bottom says. Usually, patients are visibly relieved to find out their hospital is in network. Bearing this good news is a jumping-off point to talk about what is not covered.

"It helps to promote trust and transparency about pricing and payment expectations," Bottom says. "Sometimes, that conversation leads to learning about alternate healthcare resource options."

However, registrars are careful not to sound like they are discouraging the patient from seeking care in the ED. "Unhappy patients or family who feel their right to access has been obstructed may complain to CMS," Bottom cautions. Patient access keep patients informed without implying they should go elsewhere and collect balances owed — yet not too aggressively.

"We have found good success collecting payment in the ED," Bottom reports. "But we continually work with our staff to maintain the right balance."

Registrars use a matter-of-fact, conversational tone. They also pick up on signs that it is just not the right time to talk about money, such as when a physician is reviewing test results.

"We coach our team to be aware of activity in the room and to always remain sensitive for the situation at hand," Bottom explains.

Assuming the timing is right, registrars say something like this: *"Ms. Smith, I verified your insurance with (name of plan), and it's active for today's ER visit. We are an in-network provider for (name of plan), and your plan with (name of patient's employer) covers (coverage details). Your deposit for today is ($ ___)."*

Pressing someone to take care of the balance right away is discouraged. "Pushing too hard for payment is off-putting and could appear insensitive," Bottom says. To bring this message home, employee incentives are based on patient satisfaction, not how much they collect.

Overall, the ED registration encounter is meant to offer patients "a total package of service and education," Bottom says. Staff do not just ask for payment; they also confirm the patient's identity and demographic information and obtain consent forms. While taking care of these routine tasks, registrars establish a rapport with the patient.

"Our team's goal is to empower patients with billing and payment information vs. wearing a collector's hat," says Bottom, noting that the collection part of the conversation is consistent. "We always talk about it, we always ask, and we aren't shy about the conversation." ■

Self-Pay Team, Financial Counselors Find Common Ground

Financial counselors and self-pay team members always worked jobs that overlapped somewhat at Bronson Methodist Hospital and Bronson LakeView Hospital in Michigan. Still, the two groups of employees rarely, if ever, met in person. That changed after four hours spent working alongside one another.

For financial counselors, "it was an eye-opening experience. They saw that self-pay staff are just as busy as they are," says **Darlene Powell**, patient access manager at Bronson Methodist.

The two roles are different in some important ways. The self-pay team works strictly offsite, interacting with patients only over the phone. Typically, conversations are about past due bills. In contrast, financial counselors meet with patients at the bedside. "We don't get into deep details of the patient's bills," Powell says. Instead, financial counselors help patients apply for Medicaid, and work with Department of Health and Human Services workers as advocates for the patient.

Financial counselors were very surprised at how high the call volumes were, fielded by the self-pay team, and how quickly they worked.

"The self-pay staff are usually trying to keep calls at a short time frame so the

queues don't back up," Powell explains. Financial counselors are used to a difference pace with their face-to-face encounters. Other people waiting can see there is someone else receiving help. "They know there will be a wait," Powell says. "The financial counselor can spend additional time with a patient when necessary."

What was most amazing to financial counselors was the speed at which their colleagues switched back and forth between multiple screens. Financial counselors learned some shortcuts. "Epic has several different ways you can see the same information, and some ways are shorter than others," Powell explains.

Initially, the plan was for the self-pay team to shadow financial counselors, too.

"Due to staffing issues in self-pay, we have had to delay that for a while," Powell reports.

Self-pay staff are eager to improve their communication skills. They believe they can learn a lot by observing in-person encounters. "It's much harder to tell a patient you aren't able to assist them financially over the phone than in person," Powell notes.

At one point, multiple phone calls took place between the teams. "These calls centered around patients with complex financial needs," Powell recalls. The two groups figured out how to avoid all the back-and-forth. The problem was that billers were hearing questions that were beyond their expertise. Patients wanted an explanation of why a decision was made to deny them financial assistance. Some asked that a decision to deny charity care be reversed.

"We created some great reference guides on the top questions that self-pay deals with daily and correct responses to them," Powell says, noting that this included definitions of terminology, codes, and billing indicators. "This was a big win for the staff. They really appreciated it." ■

Push Back if Planned Changes Are Bad for Patient Access

Both patient access and billing staff are part of the revenue cycle; however, they do not really feel like colleagues since they never see one another at work. That has changed at Stanford Children's Health in Palo Alto, CA. "We've done a lot of work to create opportunities for roles to overlap," says **Shawn Tienken**, MHA, director of revenue cycle operations.

It starts at the top of the department. Patient access and billing leaders (from both the hospital and professional side) meet for a few hours every Monday afternoon. "It's a forum to talk out major revenue cycle issues, and how proposed changes might affect one side or the other," Tienken explains.

Right from the start, new revenue cycle hires receive training that tells them where they fit into the process. "We try to lay some foundation," Tienken says. Trainers explain how errors made at the beginning of the patient's hospital stay (during registration) cause problems in coding, billing, and charge capture.

But it does not end there. Patient access staff learn about the "back end" very well by observing those employees at work. "That's where people get exposed to the workflows of their peers," Tienken says.

This familiarity reduces the temptation to complain about unproductive or mistake-prone counterparts. Sometimes, it even leads to someone realizing he or she would rather work a different revenue cycle role. For instance, some billers really want to interact with patients. Similarly, registrars sometimes love the culture of the back end office and want to be a part of it. "Employees are encouraged to pursue open roles in those departments when they become available," Tienken notes.

Revenue cycle managers are expected to provide coaching and guidance to staff who are seeking to change roles. This way, says Tienken, "they develop the skills necessary to succeed in their desired position."

When any changes are planned for the revenue cycle, both the front and back ends want a chance to weigh in. Often, some unintended consequences are brought to light. For example, billers always want more specificity that can avoid denied claims. They do not realize that it causes delays in the registration process. "By adding more options for people to pick from, it slows things down, and increases the

likelihood of errors," Tienken says. Recently, billers wanted registrars to identify which medical group the patient was part of. This was because certain services needed to be billed to the medical group rather than the health plan. "Revenue cycle leaders weighed these billing needs against the additional complexity this would introduce to registration processes," Tienken says.

The group brainstormed and developed ways to use automated tools to extract the information billers required. This prevented claims denials without making registration inefficient.

Even departments outside the revenue cycle want more information obtained at registration. Recently, clinical leaders complained that registrars were not always obtaining the referring provider. They wanted this information to develop and enhance relationships with the referring community. "They said, *'We want you to hard stop everything on the front end, so if you are not capturing the referring provider, this will make sure you do,'"* Tienken recalls.

Patient access leaders objected, with good reason. They explained that the process just would not work in certain situations. For an inbound emergent transfer patient, the process change would affect clinical care negatively. This is because the "hard stop" would prevent the clinical team from placing necessary orders for the patient since the referring provider usually is not known at that point. The ensuing dialogue led to a good compromise. Registration staff are alerted to collect the referring provider but would not be stopped from proceeding without the information, if necessary. "Any missing records would be routed to managers for review and correction," Tienken says.

On the other hand, patient access is seeking to automate some registration processes. Billing expressed some concerns about this, and asked for the chance to offer input before the system starts choosing which coverage should be applied. "We are seeing a lot of denials because the coverage is not being differentiated," Tienken explains.

Mistakes made at registration are flagged to ensure only a correct and "clean" bill is sent. The person who made the mistake is the one who corrects it. "We don't have people on the back end fix them. We push them right back to the front end," Tienken says.

This process reinforces the "downstream" effect of registration errors on hospital revenue. "When people say, *'How come you are holding onto $100,000 in claims?,'* we say, *'Go talk to the front end leaders,'"* Tienken says.

Patient access embraced this approach to fixing their own errors. "They have put in work queue volume tracking as part of their annual goals for staff," Tienken notes. Patient access staff are fully informed on the volume and dollar value of the errors they make and how quickly they are corrected.

One reason for errors on the patient access side is constantly changing payer requirements. Sometimes, changes are made without patient access even realizing it.

"The front end doesn't necessarily have a channel to know the requirements are changing. Usually, the back end starts noticing denials," Tienken says.

This is covered at the weekly meetings. For instance, billing leaders alert the front end that a process is needed to capture a specific piece of information for a certain payer. Recently, one managed care plan required referrals from a patient's primary care provider prior to surgery, even if that same primary care provider had referred the patient for specialty consultation.

"We needed to alert patient access staff to be on the lookout for the primary care provider referral," Tienken says. Registrars no longer schedule surgery on short notice if the referral is not present.

Other times, the issue is that a medication or diagnostic test now requires prior authorization, or that authorization time frames are unacceptably long. Revenue cycle leaders have engaged in much discussion around payers not complying with their own contractual obligations where authorizations are concerned.

"We see denials all the time that we don't think are appropriate," Tienken says. Revenue cycle leaders need to go through a time-consuming appeal process. Turnaround time for authorizations keeps growing longer. "We quite frequently see that as an issue," Tienken adds.

The department just set a goal of getting a certain percentage of authorizations secured in advance. To achieve this, both sides have to work together. The front end has to keep the back end informed on obstacles with payers; billers have to report on "no auth" denials they are seeing.

"If we succeed, everybody gets a bonus," Tienken says. ■

'Level of Service' Denials Cropping Up; Revenue Lost

Patient access departments are seeing yet another new reason for denying claims: Payers are disputing the "level of service" for which they were billed. For instance, health plans often claim that patients failed to meet the criteria for inpatient care, meeting the criteria for observation status only instead.

"Insurance plans have developed their own restrictive procedure lists," says **Latayvia Law**, a patient access associate administrator at Jackson Memorial Hospital in Miami.

Often, these criteria do not follow the CMS inpatient procedure list. These conflicts cause a lot of confusion, which can be costly for hospitals. Departments must maintain, train, and follow different protocols for different payers to avoid level of service denials. For patient access, says Law, "this causes an administrative burden."

Approximately 1.3% of net patient revenue is lost at Jackson Memorial because of level of service denials, according to Law. "Some diagnoses are only getting authorized as observations." Sometimes, patient access finds this out while the patient is still in the hospital. More often, the claim is denied after the fact. Most of these are reported as authorization denials.

"But they are really level of care," Law notes. "Payers often say missing documentation is the reason for the denial."

To stop the denials, "patient access has to be vigilant," says **Lisset Bassas-Prado**, director of eligibility and patient access at Jackson South Medical Center, also in Miami. Case managers can be of some help if they find out about the problem early enough. Collecting good data on the problem also is essential. "We need to predict and prevent denials using historical trends," Bassas-Prado offers.

Patient access cannot do it on its own. It is necessary to turn to the hospital's managed care department. This collaboration can give patient access some good data on how many level of care denials are occurring. They also can find out exactly how much revenue it is costing the hospital so the issue can be raised effectively with payers.

"Addressing this through contract negotiations would yield sustainable results," Bassas-Prado says. ■

COMING IN FUTURE MONTHS

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- Hospitals face public outcry for suing patients for unpaid bills
- Patients need warnings about health insurance scams
- Preservice calls can stop surprise bills for underinsured

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