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INSIDE

Relias Media
From Relias

APRIL 2021 Vol. 40, No. 4; p. 25-32

The COVID-19 Vaccine Quarantine: A New Staffing Headache

Many patient access areas have been working short-staffed because so many registrars have to quarantine after COVID-19 exposure. Consequently, registrars are struggling with poor morale and unexpected overtime.

At Albany (NY) Medical Center, registrars took on an entirely new role: scheduling vaccines for the community, after the hospital was designated as a regional hub for COVID-19 vaccine distribution. "We needed to provide several staff for several weeks. Thankfully, the vaccine came in at a time when normal volumes were still low," says **Brenda Pascarella**, CHAM, director of patient access.

The department provided schedulers for vaccine clinics without affecting normal operations too much. Concurrently, patient access staff were receiving the vaccine, causing additional staffing shortages. The department did not vaccinate all registrars at once to avoid potential short-staffing. "We did have several staff with side effects. The fact that we were able to stagger was helpful," Pascarella says.

At Stillwater (OK) Medical Center, all patient access staff who were interested in taking the COVID-19 vaccine have now received both doses. "Our ER registration staff were included in Phase 1 with the clinical staff," says Patient Access Director **Renee Swank**, CHAM.

The department paid patient access staff for the time spent seeking the vaccine. "Some were lucky enough to receive their shot in-house, but some had to travel to an offsite location," Swank reports.

About 70% of the patient access department wanted the vaccine. The 30% who elected not to be vaccinated reported their doctor had recommended they not receive it because of a health concern. "Some younger staff were hesitant due to unknowns with fertility," Swank notes.

Most staff reported no side effects, or only arm soreness. A small number had to miss one to three days of work after either the first or second doses because of elevated temperature, headache, or body aches. "Staffing has become much more manageable due to the high volume of staff who received vaccines," Swank says.

For months, an unpredictable number of registrars were out quarantining at any given time. "Staffing gaps have been covered by our float registrars, who are trained to work in multiple areas. This has been a life-saver," Swank says.

The department's career ladder saved the day. One of the key requirements is to be cross-trained to work in an additional area of patient access. These flexible

HOSPITAL ACCESS MANAGEMENT

Hospital Access Management **(ISSN 1079-0365) is published monthly by Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468. Periodicals postage paid at Morrisville, NC, and additional mailing offices. POSTMASTER: Send address changes to *Hospital Access Management*, Relias LLC, 1010 Sync St., Ste. 100, Morrisville, NC 27560-5468.**

GST Registration Number: R128870672.

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registrars receive a pay differential and agree to work any shift, any day of the week. "We try to plan their schedule a week in advance. But sometimes it changes due to staff illness or other unscheduled events," Swank explains.

The float registrars work at any registration area at Stillwater Medical Center, as well as two smaller hospitals (Stillwater Medical-Perry and Stillwater Medical-Blackwell). "If we don't have an open shift for them to cover, the floats assist with training new employees," Swank notes.

Even with float registrars stepping in as needed, some registration areas remained short-staffed. Other areas managed with existing staff, but incurred an unusual amount of overtime. "Our department has typically been able to keep overtime at a minimum, but not for the past several months," Swank says.

Overtime is stabilizing to typical minimal levels. At one point, though, schedulers and preservice staff were putting in five to 10 extra hours a week. "Burnout was a concern," Swank says. "We did things like handwritten thank you notes, gift cards, and one-time cash bonuses to express our appreciation."

Going forward, a vaccinated department and community will mean less upheaval with staffing. "As a leader, I am thankful that most of our staff are fully vaccinated," Swank says. ■

ED Patients Worry About the Bill, Registrars Can Intervene

People come to the ED sick, injured, or in severe pain. This is not an opportune time to ask someone for a $100 copay — or, worse, inform them they are responsible for the entire bill.

"It's difficult to tell someone with no insurance that they are going to owe X amount of dollars and ask how they'd like to pay," says **Jennifer Sanchez**, a senior patient access services representative in the ED at Phoenix-based Banner Health.

To help with this, revenue cycle leaders added two new frontend financial assistance tools. ED registrars offer patients payment plans based on the estimated amount due, or a Banner Health-branded credit card with a quick approval process. "It changed the thinking from 'We have to collect' to 'I know how I can help this patient,'" Sanchez says.

For at least one patient, a financial conversation with a registrar was quite possibly a life-saver. The patient was anemic, had lost a lot of blood, and needed an immediate blood transfusion. The patient was just about to walk out of the ED and leave against medical advice because she did not have insurance. The physician assistant (PA) asked an ED registrar to speak to the anxious patient. Sanchez immediately came to the bedside and gave a price estimate for the ED visit (and another estimate for ED observation, since there was a possibility the woman would have to stay overnight).

Next, Sanchez went over all the options for help (charity care, financial assistance, and applying for the state's Medicaid program). "I have never seen a patient more appreciative. She ended up staying," Sanchez reports.

The patient did not think she would be approved for Medicaid because she was employed, but Sanchez encouraged her to apply anyway. Meanwhile, the patient set up a payment plan, with the understanding that it would be discontinued and payments refunded if Medicaid ended up covering the ED visit.

"Emergent medical care can quickly change a patient's income status, making them eligible," Sanchez explains. Patients' status might change because income is lost due to extended hospitalization or a long recovery period.

The PA later told the registrar if the patient had left the ED, there was a good chance she would not have survived. "There are a lot of people who don't seek the care they need because of financial issues or no insurance," Sanchez says.

Remembering this makes it easier for registrars to perform their jobs, since the reality is many people already are worried about the bill, sometimes enough to leave without care. "When we see firsthand that it could literally be a matter of life or death, it makes it a little easier to start talking about money," Sanchez says. "We know we have a solution for them."

Recently, a family was about to leave the ED at Nemours/Alfred I. duPont Hospital for Children in Wilmington, DE. "They were unsure whether or not they were even allowed to be seen in the ED because they did not have insurance," says **Victoria Foster**, a patient access service specialist in the ED.

Right away, Foster put the family at ease by stating, "No matter what, we will take care of your child. We have financial assistance programs that will help you. We'll worry about the rest later."

Foster held off on completing the registration until after the child had received care and the family had calmed down. "When we got to the financial responsibility section of the registration, I set the family up with a telephone appointment for financial services," Foster says.

The family was surprised to hear there were assistance and uninsured discount programs, payment plans, and the possibility of Medicaid coverage. "This father was extremely grateful for everything we were able to do for him," Foster recalls.

Now, patients can book their own financial services appointments online. If the family is at the ED during office hours, the family can get in touch right away. "However, we seem most successful with calling the family using an appointment time," says **Paula Jermyn**, manager of family financial services at Nemours.

For the family, it is reassuring to know the financial aspects of the visit can be handled later. For financial advocates, it is easier to engage in a thorough discussion when emotions are not running high during the actual ED visit. "My team likes it because we know the family is expecting our call, and, typically, is responsive to our outreach," Jermyn says.

The anxiety of not knowing the ED visit cost is enough to prompt some patients to consider leaving. At Children's Hospital Colorado in Aurora, patient access has started providing cost estimates in the ED. "This will be a valuable tool to equip our patient access team. With the cost estimates, we expect to see an increase in overall collections," says **Suanne Kindel**, operations manager for patient access and financial counseling.

All ED registrars participated in customer service training recently. The focus was empathy and compassion when collecting copays. "Our clinical team often informs patient access of possible challenges or sensitive situations prior to completing the registration," Kindel says.

Abuse, trauma, or behavioral health issues are common. Registrars start by saying, "We are sorry you are in the emergency room. You are in good hands."

Registrars do attempt to collect, but they do it with compassion. "We always say, 'We can take care of your copay now, so you can focus on your child's recovery,'" Kindel says. ■

Top Copay Collectors at Pediatric EDs

Asking for copays is never easy, but it is especially difficult in the ED. It is even harder if the patient is a child.

"Not everyone is successful at this task. We provide ongoing training, which includes scripting," says **Leslie Velez**, manager of ED registration, admitting, financial counseling, and cashiers at Connecticut Children's in Hartford. By performing their job well, registrars reduce worries for families — and bad debt for the hospital. "This is why the team addresses copay collection at the time of service," Velez says. Here, some top ED collectors share their copay collection topics:

Kelly Pfalzgraf, an ED registrar at Connecticut Children's, starts with a genuine smile, a pleasant introduction, and good eye contact. After completing a full registration, Pfalzgraf begins by saying, "You do have a co-pay today of X. How would you like to take care of that today?"

"I try to hold eye contact when I ask," Pfalzgraf says.

The next step depends on what the family says. If the family asks, "Can you bill me?" Pfalzgraf matter-of-factly says, "We ask that you pay at the time of service." If the family says, "I'd like to be billed," Pfalzgraf asks, "Would you like to pay anything toward the balance today?" If the family says anything about inability to pay, Pfalzgraf asks, "Would you like information on our financial

counselors?" Sometimes, families do not know what a financial counselor can offer them, so Pfalzgraf explains they can create a payment plan, or see if the family qualifies for assistance.

Pfalzgraf always checks to see the patient's insurance card has been scanned in. If it is not in the system, she asks for the card. "While they are in their wallet, I will say, 'While you're in there, you also have a copay today of X,'" Pfalzgraf says.

David Ferrer, another ED registrar at Connecticut Children's, starts off by introducing himself as an ED registrar to make his role clear to patients. In a previous job as a bank teller, Ferrer developed a habit of finding something to connect on when making conversation with customers. He does the same thing now with families in the ED.

Establishing a rapport makes it easier to ask for the copay. Ferrer does it this way: "There's a copay due for the services rendered today of X. We understand that with the pandemic, there might be some hardships, but we are here to help. We accept cash and credit. How would you like to pay?"

One child came to the ED recently because of a rash. Ferrer saw the family's ED copay was $250, but the child's mother mentioned losing a job recently. "I kept this in the back of my head when asking for the copay," Ferrer recalls.

The woman said she was sorry, but could not pay the $250. Ferrer responded, "I completely understand. We are here to help you through this."

The parents did not believe they could pay half the copay either, but did agree to pay $25. "I offered the financial counselor's information. The parents thanked me sincerely," Ferrer reports.

Victoria Foster, a patient access service specialist in the ED at Nemours/Alfred I. duPont Hospital for Children, stays sensitive to people's emotions. "I always use a very light, sympathetic tone of voice, and I have a few different ways that I ask for the copay," Foster says.

Timing is important. Once the child is medically stable, parents are much more likely to be willing to handle the copay. "If they want to pay it, I take it. If they are not able to, I let them know that it's not a problem, and we can bill the copay," Foster explains.

If the amount is the issue, Foster makes it clear a partial payment is OK. It is better than billing someone for the entire copay. "If they are upset because they can't or don't want to take care of the payment, I let them know to contact our financial services for help," Foster says.

For self-pay patients, Foster makes sure they are aware there is no insurance listed in the chart. This gives the family a chance to explain where they are in the process of obtaining insurance. Some say something like, "I filed for Medicaid, but am still waiting for approval." Foster then says, "For families that have no insurance, we usually ask for a $250 deposit. Would you be able to put anything toward that today?"

"Most of the time, families do not want to pay it, but occasionally they do," Foster notes.

For those who do not pay, Foster offers an appointment for a phone call with financial services and financial assistance brochures with contact information. "We ensure that they have the information that they need to seek assistance," Foster says. ■

'One-Stop Shop' Self-Registration Is Reality for Patient Access

At Evanston, IL-based NorthShore University HealthSystem, patients can schedule appointments with almost every specialty, and also for services such as radiology and colonoscopies. "We allow both new patient and established patient scheduling, and some procedural scheduling," says **Cynthia LaCourt**, MBA, MM, FACHE, CCS-P, assistant vice president of revenue cycle.

Patients can update demographic and insurance information, check in, verify registration information, upload insurance card images, and pay copays and outstanding balances. Patients also can auto-arrive for appointments, using their phones' geolocation capabilities. Now, LaCourt's department is going even further. "We recently implemented estimates," she reports. Patients choose applicable physician and hospital services, and generate price quotes based on their insurance or as self-pay.

For some patient access areas, all this self-service means less call volume and less preregistration work. There is a caveat: Patients are looking for a quick, easy experience. If they do not get it, they will revert to the old, labor-intensive system. "If self-service is too cumbersome, with lots of questions and multiple steps, patients will pick up the phone and call because it's easier," LaCourt says.

To prevent this, patient access departments are investing in technology to give patients the self-service experience they expect. Indiana University (IU) Health is piloting IU Health Mobile Registration. These steps occur:

• When a patient schedules an appointment, a text message is sent

automatically shortly before that appointment.

• At that point, the patient completes check-in. That includes securely submitting photos of government ID and insurance cards via their mobile device. Patients can add demographic information and e-sign required forms.

• On the day of the appointment, patients receive an additional text. This allows them to check in from their mobile device when they are within one mile of the appointment address and one hour of the appointment time.

"This step alerts our care team to the patient's arrival. We offer a concierge-style reception, and guide the patient to their appointment," says **D.J. Plavsic**, MBA, CRCR, executive director of patient access and the revenue cycle.

For returning patients, the most recent registration information is prepopulated. Those patients look at what is on file and update as needed, without entering it all again. "This saves time for patients. All registration data and images feed directly into our electronic medical record system in real time," Plavsic says.

IU Health is in the final stages of development for the Mobile Registration product, to be launched this spring.

"Across the industry, progress in deployment of this type of technology has been slowed due in part to complex systems architecture and a lack of ideal functionality," Plavsic notes.

During the initial rollout, the focus was on scheduled appointments and insured patients. "We are looking forward to enhancements in future phases, with increased functionality," Plavsic says.

Coming next: appointments with a broader range of patients, including children; unscheduled walk-ins; ED visits; and patient estimates delivered by text. "Our goal in 2021 is to have a one-stop shop mobile environment," Plavsic reports. "Patients will perform all access-related functions — scheduling, registration, viewing estimates, and checking in — from the same platform." ■

More Work Needed to Protect Underinsured Patients

Many working-age adults lacked stable health coverage in the first half of 2020, according to a report by The Commonwealth Fund.[1] "What is surprising is the large share of people in employer plans who are underinsured," says **Sara R. Collins**, PhD, vice president of health care coverage and access at The Commonwealth Fund and report co-author.

About one-quarter of people with employer coverage pay high out-of-pocket costs or deductibles relative to their income. "This trend has been driven by growth in deductibles over time," Collins says.

The number of underinsured adults has increased since 2010, when only 7% of people with private health insurance paid deductibles that were 5% or more of their income (a key indicator of underinsurance). Privately insured adults with deductibles of at least $1,000 more than doubled from 2010 to 2020 (from 22% to 46%). "The larger problem is in the individual market and marketplaces, where about 40% of enrollees are underinsured," Collins explains.

Benefit requirements under the Affordable Care Act have improved insurance coverage. "But, clearly, more work is needed from federal policymakers to protect people against high out-of-pocket costs and encourage access to timely care," Collins offers.

Early identification of underinsured patients buys time to find solutions. "A facility should be financially clearing 100% of its patients preservice — or, at the very latest, before discharge," says **Jonathan Wiik**, MHA, MBA, principal of healthcare strategy at TransUnion Healthcare.

Huge hospital bills for people with insurance often happen because somewhere along the way, a provider was out of network. "This is often discoverable in preservice eligibility and estimation processes," Wiik says. The following are some contributing factors to surprise hospital bills for underinsured patients:

• **Health plans do not properly communicate which providers or facilities are in network.** It is the patients' responsibility to understand the providers contracted for their health plan, but it does not always happen. Hospitals also keep a list of contracted providers, but these are not always up to date. "This leads to frustration and confusion, as the patient, provider, and payer could have three different lists," Wiik observes.

• **Hospitals do not always properly communicate which providers are in network for admitted patients.** This prevents the underinsured person from making an informed decision. "Admitted patients are more challenging, as many [admissions] are not planned," Wiik says. This makes it difficult for providers to engage in financial discussions with patients in advance about coverage, network status, and costs.

• **Some hospital contracts do not include reciprocity language for non-contracted physicians.** "Reciprocity is a Medicare rule that is loosely followed

in some cases, where hospitals can align their reimbursement rates with their independently contracted physicians," Wiik says. Under this rule, if certain conditions are met, Medicare will accept and pay claims for a substitute physician at the Medicare rate. "In the case of commercial insurance, payer-provider contracts can reverse this," Wiik says.

For example, contracts can state: "In the event a patient presents to the facility with in-network benefits, and the attending physicians are out of network, the out-of-network physicians agree to the reciprocal usual and customary in-network rate for the service."

"In most cases, hospitals encourage — and many require — that as part of the credentialing process, when a provider receives admitting privileges at that facility, they also receive rate reciprocity or the prevailing in-network benefit rate," Wiik says.

These agreements between the hospital and providers can be enigmatic. "Hospitals should look for gaps," Wiik offers. "This is especially important for hot spots of out-of-network care."

These "hot spots" include radiology, pathology, surgery, anesthesiology, and emergency medicine. Physicians from these specialties most often are out of network with the hospital. "These physicians, if credentialed to practice medicine at the provider facility, should also be matrixed to the facility insurance contracts where possible," Wiik suggests.

• Patient access staff do not always detect the out-of-network providers before the bill is sent. Most insurance contracts use the terms "fair market value" and "usual and customary rates" for how patients should be charged when the health plan offers some out-of-network benefit. "In the absence of this, 100% of the charges fall to the patient," Wiik observes.

Most providers have a sliding scale discount fee policy for self-pay patients. This same discount should be given to patients who receive out-of-network bills, according to Wiik: "In these cases, the difference, or nonpayment, is classified as a bad debt adjustment."

Hospital charge masters often are not an accurate reflection of the cost of care. "As such, holding the patients responsible for the inflated charge is not ethical," Wiik explains.

Many organizations discount the charges down to the net deduction in revenue to reflect the average insurance discounts. "There is still a gap between what the patient can afford and what is owed," Wiik says. For instance, a patient may present to the ED at a hospital that is out of network, and the charges are $35,000. The insurance net deduction in revenue may be $10,000. The patient is billed $10,000, but pays an in-network $150 copay.

• Patients do not understand the scope of the coverage and network of their insurance plans. "[Plans] were not designed to cover care anywhere for anything. They do have limits," Wiik says.

Patient access departments cannot control all this, but education is one way to stop surprise hospital bills for underinsured patients. At Stony Brook (NY) Medicine, education has become a major part of the patient access role. "We have increased patient access staffing considerably compared to five years ago to respond to the many variations in benefit designs and cost-sharing responsibilities we need to communicate to our patients," says **Laurene Molino**, interim director of patient access services.

Registrars explain copays, deductibles, or co-insurance when preregistering patients for elective procedures and in the ED. Patients generally do not know too much about their coverage. Some are shocked at the dollar amount of their cost-share. "Many patients produce their insurance card, but really do not fully understand the type or scope of coverage their individual policy provides," Molino says.

One thing that commonly confuses patients is the difference in cost between freestanding diagnostic centers, outpatient centers, or inpatient hospital settings. This can lead to surprise bills for insured patients. It is one of the many issues registrars have to explain to patients. "Benefits may vary significantly depending upon the site of service," Molino says. ■

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Make Patient Access Evaluations More Transparent

Just as hospitals are becoming more transparent about costs and the quality of clinical care, the same is true for revenue cycle staff performance evaluations. "We are a very open book with our staff," says **Jennifer Cox**, MBA, revenue cycle director at Brewer, ME-based Northern Light Health. Staff can check on how many registrations they have completed and the accuracy of each. They also can see how the overall department is performing — speed of calls, wait time duration, and how many calls are going to voicemail. "We are a team. Why keep it a secret?"

Cox asks. Clinical areas are used to publicly reporting quality measures. By following suit in revenue cycle areas, says Cox, "it provides an opportunity to offer support."

Registrars can see each other's current call times on their computers. If a registrar notices someone is on an unusually long call, it is an opportunity to help. The co-worker can offer assistance, either by taking over the call or providing a piece of information. If a supervisor notices an employee spends more time on calls than colleagues, extra training may be needed.

"Maybe they are struggling with how to get off a phone call, or maybe they get confused about insurance," Cox offers.

But just because call times are visible does not mean everyone has to be equally fast.

"We look at what can we do to help staff be the best they can be for the job. We don't need every team member to be the same," Cox explains.

One registrar logged long call times and low registration volumes, but it was because she was going above and beyond for patients. One patient in a wheelchair described how the registrar escorted him all the way to his appointment location.

"Patients were always praising how kind she was," Cox reports.

Transparent metrics call attention to department stars. One registrar always pulled up a list of patients who needed registrations and organized the workload with colleagues.

"As lead of a pod, she now updates the spreadsheet and pushes the group to get it all done," Cox says.

Patient access leaders no longer have to guess how to help struggling registrars.

"Maybe they need help in getting through the system, collecting money, talking to patients, or how to schedule," Cox offers. "There is a lot to every revenue cycle role."

At Rockledge, FL-based Health First, patient access leaders are committed to transparency.

"It fosters an environment of clear expectations and staff accountability. Transparency allows staff to see exactly where they stand," says **Michelle Fox**, DBA, MHA, CHAM, director of revenue operations and patient access.

Leaders do not speak in generalities; they offer specific feedback on exactly what registrars are doing incorrectly so the mistake will not happen again. This eliminates much rework because errors are fixed before claims are sent. "It helps with decreasing revenue loss, timely billing, improving the clean claim rate, and decreasing the cost to collect," Fox says.

Health First's revenue cycle department has made transparency an important focus in several ways:

- Leaders email daily reports of results for individuals, teams, and the organization.
- Registration areas publicly display daily, weekly, or monthly progress.
- Staff receive timely feedback in a huddle at the beginning of each shift.
- The department comes up with fun challenges to hit certain metrics. "We have multiple ways to recognize and reward for optimal performance," Fox says.

Of all the revenue cycle metrics, accuracy rate is by far the most important.

"It affects numerous downstream processes," Fox explains. If information is not obtained at the time of registration, or is incorrect, it delays billing. "In turn, that negatively impacts cash collection," Fox adds.

Registrations per hour also are of great importance. "It allows us to evaluate proper staffing and identify any barriers preventing an efficient workflow," Fox says. If anyone is not meeting standards, it is discussed openly. The department relies strongly on one-on-one coaching.

"We deliver real-time feedback and address any performance issues with the staff," Fox says. ■

Data Are the Key to Avoiding Claims Denials

Claims denials have increased by 11% nationally since the onset of the pandemic, according to an analysis of 102 million hospital transactions at more than 1,500 hospitals.[1] "The data clearly show that patient access is a key area in preventing denials," says **Nick Raup**, assistant vice president of product management at Change Healthcare. Almost half of claims denials are caused by front-end revenue cycle issues.[1] These include registration/eligibility, authorization, or service not covered.

"Take a closer look at these denials and assess what you can do internally to prevent them," Raup says.

Registration and eligibility accounted for 27% of all denials.

"Implementing a process to check eligibility at multiple points throughout the revenue cycle will go a long way in preventing this common denial from occurring," Raup says.

Use the CMS database to see if the patient has existing Medicare Advantage coverage. Datamine to identify existing commercial coverage for Medicaid enrollees. Implement technology that gives real-time access to payer benefit information.

Eighty-six percent of denials might be avoidable (about 25% of these are

not recoverable). About one-third of the denials are "unequivocally" avoidable (of that group, 48% of the revenue cannot be recovered).

"The biggest items in this area are the clinical denials for authorization and medical necessity," Raup says.

Clinical determination is subjective. Therefore, it is hard to know if the health plan will overturn the denial on appeal.

Overall, the findings point to the need for hospital revenue cycle departments "to become more data-driven," Raup says. If patient access can find the root cause of a denial, that prevents much more revenue from disappearing later. It is important to identify and categorize the reasons for denials.

"This ensures that revenue cycle staff are working on the most appropriate claims," Raup says.

Some denials are unrecoverable or unlikely to be overturned. Those are not worth wasting time.

"An example of this type of denial is where a patient receives behavioral health treatment and their insurance does not cover it," Raup observes.

Non-covered service denials are common at UChicago Medicine. Health plan reps confirm an authorization is not needed for a scheduled service.

That is good news for the patient — until the claim is denied for a totally different reason.

"It turns out that the service was never covered by the plan in the first place," says **Michael Sciarabba**, CHAM, MPH, director of patient access services.

First, registrars call the health plan to ask if authorization is required. The health plan rep, correctly, says no. No one realizes that it really does not matter, since the service in question is an excluded benefit.

"We are seeing this happening with a lot of high-cost, specialty care," Sciarabba says.

It happens with capsule endoscopies, cochlear implants, and heart loop monitors. The patient is scheduled, and no one has any idea the service is non-covered.

Sometimes, the health plan rep cannot even give a yes or no answer. The registrar then has to speak to a supervisor just to find out if the service is covered. If not, patients usually do not blame the health plan; they blame the hospital for not telling them sooner.

"The payor blames the patient, stating that the patient was given a list of excluded services and should have known their benefits," Sciarabba says.

After this happened several times, registrars now ask about it specifically.

"When they call to check if authorization is required, they also ask: Can you confirm that this is a covered benefit?" Sciarabba adds. ■

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COMING IN FUTURE MONTHS

- Why some denied claims are impossible to appeal
- ED registrars are responsible for some EMTALA violations
- Departments are surveying patients about registration
- Revamped processes needed if CPT codes change

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