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INSIDE

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Revenue Depends on Correct CPT Codes; Beware Sudden Changes

A patient is scheduled for surgery to repair an ankle fracture. All the authorizations are obtained for the relevant CPT codes. Then, on the operating table, the surgeon finds something surprising — two torn ligaments, which now need to be repaired, too.

"If you open up the patient and see something else, you are going to fix it. It's what you have to do, in terms of providing quality patient care. But we also need to be sure we are doing what's right for the hospital, too," says **Kristi Hall**, senior financial navigation and training analyst at Cooper Health in Camden, NJ.

Surgeons are right to repair the torn ligaments. The problem is those CPT codes were not included in the initial authorization request. Patient access knew this recurring issue was causing some claims denials, but the actual prevalence of the problem was unclear. "The denial categories that come back from the payor aren't too accurate," Hall explains.

Health plans often indicated claims were denied because of a "noncovered service" or no authorization in place. Patient access suspected some denials were caused by incorrect CPT codes. There was no time to delve into the complex underlying issues of these denied claims. When the COVID-19 pandemic hit, elective surgeries were canceled, creating much-needed free time. "We decided to use the time wisely by doing some deep-diving into long-standing issues," Hall reports.

The top question on the list: Why were so many orthopedic same-day surgery claims denied? Patient access staff reviewed several hundred cases for all the hospital's institutes. Ultimately, the team decided to run a pilot program with Cooper Bone and Joint Institute because of a shared senior leadership structure.

After some digging, staff discovered misleading denial codes from payors had concealed the real problem. In sum, about 40% of denials involved CPT code changes. "It was mind-blowing. We knew we had to do something, but we didn't know what," Hall says.

Usually, staff appealed denials, but that took time and resources. "The appeal process is so difficult. It is so cumbersome. It takes months on end," Hall laments.

Patient access started looking for a commercially available solution to prevent all the CPT code-related denials. Staff realized the ideal solution would be an automated tool that compares the CPT

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codes that were authorized to the CPT codes that were used. Unfortunately, no vendor offered anything like that. "We did all the due diligence. There is just no functionality to do this," Hall says.

Next, patient access tried to learn how their peers were managing the problem; no luck there, either. "We participate in a monthly call of Epic users at other health systems. We are all having the same problem, but we found that nobody has really been able to do anything successfully about it," Hall explains.

The department considered building fields into the registration system to compare CPT codes between what was ordered and what was used. That, too, was not feasible. Eventually, staff devised a mostly manual process, running a 10-week pilot test. Staff found a way to run reports on all the surgical cases with embedded CPT codes. "We were able to pull a report from our business analytics system to see the CPT codes that came off the order and what CPT codes were on the billing side," Hall says.

Registrars investigated all cases over the 10-week period, uncovering nearly 200 mismatches. "We were able to get 12% of them approved, for a net revenue of over $100,000," Hall reports. "It told us we were onto something."

Health plan time frames for authorizations are important to consider in this process. Some plans allow CPT codes on the authorization to be changed for up to 10 days post-procedure; others allow only two days. "We prioritize cases to meet the requirements while still allowing time for proper coding to take place," Hall notes.

Coders base CPT codes not on what was scheduled, but on the operative notes. Coders now go one step further. "They can go right to the authorization records and see what our insurance specialist authorized," Hall says. If it is a mismatch with what the operative notes say was used, then the coders assign a billing indicator to the account. "It then falls to our account-based work queue in Epic, and goes to our insurance specialist team, who knows that it is our high priority to work as soon as possible," Hall says.

After completing the beta project in fall 2020, the team officially went live with the process change in January 2021. Ten weeks later, they had found more than 200 cases where a CPT code change occurred. Many claims have not been adjudicated — the payor has not decided whether to pay them in full, in part, or deny them altogether. "It is not yet possible to determine what the net revenue opportunity will be. But the gross opportunity on these cases is over $1 million," Hall says.

The pilot included only same-day surgeries, not scheduled admissions for inpatients. For those cases, utilization management could fix mismatched CPT codes. For same-day surgeries, there is no opportunity to fix the incorrect CPT codes before the claim goes out. "It goes from the scheduler to the insurance specialist to the OR to the coder to the payer," Hall says.

When the organization introduced price estimates in 2019, they did it slowly and methodically, starting with MRIs, then CT scans, then routine special procedures, such as cardiac catheterizations and interventional radiology, followed by ultrasounds. The same cautious approach is used with the new CPT code process. "We will go institute by institute so we can monitor it and make sure we are being successful," Hall says.

Next, the initiative goes live at Cooper Neurological Institute. Patient access expects to gain even more revenue because of the high-dollar amount of each neurology case. "We are looking at ROI and whether we need

FTEs as this gets bigger," Hall shares. The revenue loss caused by CPT code changes is nothing short of staggering. "It's crazy to think what opportunity is out there for healthcare organizations across the country," Hall offers. "All we had to do was stop and dig and work together as a team to find a solution."

When it comes to CPT codes that change after service, "one of the biggest challenges is in the surgical space," says **Sarah Richards**, senior project specialist for revenue cycle at Spectrum Health in Grand Rapids, MI.

The patient access department revamped some processes specifically to address the problem of changing CPT codes. High-tech imaging (CTs, PET scans, and MRIs) are scheduled before the authorization is obtained.

"This makes us somewhat unique. This cuts out the need to rework the authorization as we wait for the technician to finish protocolizing the order," says **Carson Buskard**, manager of the central authorization team at Spectrum. This gives technicians more leeway to change what is authorized (e.g., an MRI without contrast to an MRI with contrast). After the test is scheduled, but before the actual visit, staff check the correct CPT codes were authorized — at least for that point.

Changes during the procedure are inevitable, most often with colonoscopies.

"Colonoscopy, by definition, is exploratory. So providers may find something unanticipated — and likely unauthorized," Buskard observes.

The team finds CPT code mismatches by comparing the case log with what is billed, before the claim is sent.

"If something were to change, we utilize a stop bill account. We do not allow the claim to go out the door," Buskard says.

The same process is used for other surgical procedures. The goal is to correct the CPT codes early enough to avoid denial.

"As long as we are ahead of the denial, we can generally get a retro authorization," Buskard says.

With some payers, once the denial has taken place it is not possible to apply for a retroactive authorization. Instead, the hospital has to initiate the cumbersome appeal process.

Spectrum employs 85 authorization team members, a dozen of whom are specifically focused on surgery. Several employees monitor accounts for CPT code changes daily. "As long as we do it quickly enough, it may not be even considered a retro authorization," Buskard explains.

Instead, the team can amend the authorization already on file. This saves weeks of time that otherwise would be spent appealing the denial. Some payors give a specific number of days where an amended authorization is possible. The bottom line is quick reaction is needed anytime CPT codes change. "We try to catch it as much in the moment as possible," Buskard adds. ■

If CPT Code Changes, Patient Access Can Obtain Payment

For patient access, denials caused by CPT code changes are frustrating. It happens most often with diagnostic radiology services and outpatient surgery procedures.

"The ordered and preauthorized service suddenly changes because of patient history, medical necessity, or some other clinical indicator that pops up immediately prior to or during the service," says **Lisa Walter**, manager of education content development at nThrive.

CPT codes change if patients reveal something that is not in the medical record, or suffers an unexpected complication. Similarly, codes might change if the provider discovers an unforeseen issue while performing a procedure. "There are so many reasons why this happens," Walter notes.

When CPT codes change, it means the prior authorization is no longer valid. For the patient, that means additional out-of-pocket costs. For the hospital, it means claims denials.

Another common example is a patient scheduled for an MRI without contrast. The radiologist finds out about a previous surgery, necessitating an MRI with contrast to obtain better images. Because an MRI without contrast was preauthorized, the hospital likely is not going to be paid for the needed test. "At that point, radiology has to involve patient access," Walter says.

Patient access can intervene to stop the unauthorized test, assuming it is not emergent or urgent — or find out if the patient wants to go forward anyway. "Regardless of what the patient decides, it's so important that patient access is involved," Walter stresses.

Patient access expertise makes all the difference on whether the hospital is paid, and how quickly. Possibly, the health plan will agree a new authorization is unnecessary — as long as the clinical records are sent with the claim.

If that is not the case, then the patient either has to reschedule the test, or sign a financial responsibility form. "If patient access is unable to be

involved in the process, things can go wrong," Walter observes.

If a patient is scheduled for outpatient surgery for an excision of a malignant lesion of a certain size, the surgeon's office preauthorizes that specific procedure. However, once the surgeon starts the procedure, she discovers the lesion is much larger.

The surgeon, based on clinical decision-making and medical necessity, performs a different procedure to remove the larger lesion, all based on what is best for the patient. "This new procedure is documented in the record and coded. The CPT code ultimately assigned was not the one preauthorized," Walter says. These are some possible outcomes:

- In the best-case scenario, the new CPT codes are caught, fixed, and the hospital is paid. "Some systems run reports at the end of every day that cross-reference prior authorizations with coded procedures and identify mismatches," Walter says.

Ideally, patient access coordinates with the billing department to place the claim on hold, giving everyone time to update the codes.

- The procedure is performed without authorization. Later, the claim is denied for no authorization, and the hospital writes it off.
- Nobody notices the wrong CPT codes until the situation is too late. First, the payor denies the claim, which takes anywhere from 20 to 45 days. Then, the hospital appeals, adding another 30 to 90 days to the payment time.
- Some claims are denied, but the payor allows a retroactive authorization. This adds another seven to 30 days to the process, but the hospital does eventually receive payment.

"Without patient access involved, it could take over 60 days just to collect from the health plan and additional time to collect from the patient," Walter says. ■

Real-Time Surveys Reveal True Feelings About Registration

The patient experience is a priority for hospitals, but typical patient satisfaction surveys are not much help to revenue cycle departments.

"Lumping staff into a single bucket makes it easy to identify overall trends of a department. But it is very difficult to identify individual staff opportunities or strengths," says **Ralene Cosby**, corporate patient access director at Brookwood Baptist Health.

Surveys usually do not reveal which registrar is responsible for the patient's impression. Also, some respond to every other question in the survey, but leave the registration-related question blank for some reason. "That counts as a negative, since it is counted as the lack of a positive," Cosby notes. It is impossible to know why the person left the question blank, which skews data.

To better understand the patient experience, registrars hand out "Please tell my manager how I did" cards. The idea is to encourage patients to respond right after, or even during, their registration experience.

"Getting an immediate response allows us to recognize staff for positive experiences quickly, as well as address opportunities timely with specific examples," Cosby says.

Patients in all registration areas except the ED fill out the cards. "The workflow in the ED is not as straightforward due to EMTALA, as well as our policy for the initial interaction to be with the triage nurse. That currently makes it difficult to offer the cards," Cosby explains.

The cards include questions about registrars' posture, demeanor, and tone of voice, along with more open-ended queries about what else could have happened to make the experience better. Hundreds of patients have completed the cards. "The comments section is the greatest source of genuine feedback," Cosby says. The department uses the comment cards several ways:

- Responses are shared with all patient access personnel to model positive behavior expectations. "We utilize scripting with specific scenarios, as well as role-playing between experienced team members and leadership," Cosby says.
- Staff who receive good responses are recognized with an extra 10-minute break. Staff who are rated poorly engage in a one-on-one conversation with a leader to discuss how the situation should have been handled. "We have found this to be exceptionally helpful, with a quick turnaround for positive behaviors," Cosby reports.
- Comments are shared with other departments (ED nursing, outpatient therapy, or radiology) that are in some way involved in the patient interaction.

Although the department uses the comments to improve the way it handles challenging situations, some patients complain about things that are outside the control of patient access.

"However, we still must respond in an appropriate and professional manner," Cosby notes.

Patients with high out-of-pocket costs or long waits after registration believe patient access has failed them.

"Some people claim that they were never contacted by anyone about a high deductible, when in fact many attempts were made by staff," Cosby reports.

Nevertheless, perception of registration is important, regardless of the facts of what happened or who was to blame.

"It transforms the dynamic of 'us vs. them' to 'How can I help this patient transform their experience?'" Cosby explains.

Some negative comments showed a need for de-escalation coaching. Staff use this scripting: "I can certainly understand being frustrated in this situation." In the end, many patients just want to be heard, without managers punishing staff.

At Sentara Healthcare's 12 hospitals, patients receive a short questionnaire in registration areas. Registrars say, "This is a survey on how your visit was today at registration. If you could take a minute, fill it out, and drop it into one of our convenient boxes, we would really appreciate your feedback."

"If they fill it out, it is entered into the system, and we get a printout at the end of each month," says **Mike M. Harkins**, CHAM, director of registration at Sentara Leigh Hospital, Sentara Norfolk General, and Sentara Virginia Beach General Hospital.

The survey gives patients a chance to write in some comments. These are tracked in two basic categories: "good stuff" and "bad stuff." One patient said the registrar "was very kind and explained everything during registration." Another said the registrar "walked me to X-ray, with a pleasant personality and very good conversation as we walked."

The compliments far outweigh the criticisms, which usually concern patients' long wait times. "The monthly report is shared with all staff and administration. If a person is named specifically, we post that in the departments," Harkins says. ■

Patient Access Technology Evolving to Meet Customer Expectations

From the patient's perspective, a great registration experience is quick and easy. "Investments should be made in technologies that reduce the time between the moment a need for services is identified to the point the service is delivered," says **Dawn Artur**, CRCR, senior director of patient access at Burlington, MA-based Wellforce.

What patients expect from registration is driven by advancements already seen in the retail and hospitality industries. "They want personalized services through technologies that recognize them as loyal customers, and self-service technologies that give them control over the process," Artur notes. How much patient-friendly technology exists for revenue cycle varies. In the Indianapolis area, self-service is common for all kinds of revenue cycle processes, says **John Woerly**, RHIA, CHAM, FHAM, an Indianapolis-based revenue cycle consultant. "However, in speaking with a number of patient access leaders on the West and East coasts, I have recently found that it is not as pervasive as I had previously assumed," Woerly admits.

Consumers expect a better, self-service registration opportunity, but hospitals are putting off technology investments that can improve the patient experience. "In one healthcare system, I was told by the C-suite that they desired to move to this new trend; however, as they would be converting their legacy EHR within a few months, they decided to wait until post-deployment when conditions and processes were more stabilized," Woerly recalls.

At another large healthcare system, leaders noted lower revenues and other competing projects (in this case, service expansions and building replacements) made it difficult to deploy self-service technologies. "Lost revenue due to the

pandemic has made it even harder. Projects are all competing for resources — time, money, and people," Woerly notes.

Some hospitals cannot add patient-friendly technology because of limitations imposed by their current systems.

"They have not yet moved to a digital platform that can provide such applications," Woerly explains.

Patients at those hospitals still have to call in for scheduling, preregistration, and upfront collections. At some locations, this could be handled on site at kiosks, but even using kiosks is not that prevalent any longer.

"Many people are uncomfortable with the use of kiosks, which is primarily the reason self-service intake is becoming more popular," Woerly reports.

To really create a registration experience consumers expect, including self-service options, hospitals must "consider many issues beyond a simple cost analysis," Woerly says. High expectations are a worry. Patients will be disappointed if they expect it to be as easy as shopping at Amazon. "Consumers expect top service experiences, including live chat if they have questions while self-registering," Woerly says.

Artificial intelligence, machine learning, and predictive analytics all are available. Slowness to adopt these new tools stalls progress on a better registration experience.

"New technologies and processes are essential to allow self-service intake," Woerly says. ■

Financial Counselors Find Unmet Needs at Vaccine Clinics

Everyone has to wait 15 minutes after receiving their COVID-19 vaccine. Financial counselors at Spectrum Health make good use of these 15 minutes.

"While people are waiting, my team uses that opportunity to walk around and ask if they need help," says **Elisa Contreras**, manager of financial counseling.

At Spectrum Health's pop-up vaccine clinics, which are publicized on social media, financial counselors make the rounds, asking if anyone wants to apply for Medicaid, needs any state benefits (e.g., food stamps or emergency assistance), or needs help making a primary care appointment. "Right there in the moment, we help and get things going," Contreras reports. "It feels great to help the community." Financial counselors, who are bilingual, are finding this is a great way to help with unmet needs of underserved communities. Some people lack transportation to travel to vaccine sites. "We are removing that barrier," Contreras says. Spectrum established vaccine clinics at community locations, such as senior centers and churches. "About 60% express some type of financial concerns," Contreras says. If patients decline services, financial counselors offer a business card to share with friends and family. "Most of the community members mention that a family member needs assistance," Contreras says, adding that financial counselors are receiving many calls from people who were referred this way.

Sometimes, the situation is complex enough to require follow-up with a financial counselor. If so, it is handled at one of Spectrum Health's locations in the same ZIP codes as the pop-up vaccine clinics. Financial counselors are there twice a week. This allows for an in-person meeting; often, this is the time to go over how to complete applications.

On site, financial counselors ask: Do you have a hospital bill right now that you need help with? One married couple admitted they were worried about an outstanding balance. After checking her hospital account, it was determined the couple was eligible for full financial assistance, and the form was completed. "The two patients stated, 'God bless you for helping us in these hard times. It's a great program. We came for the vaccine, and you have no idea how much you just helped us.'"

Another man was distraught over a $700 balance that he could not afford. The account had gone to collection. After a quick screening, the financial counselor saw the man qualified for assistance, but it had not been discovered by anyone previously. The financial counselor removed the account from collections and wrote off the balance on the spot. It was a huge weight off the man's shoulders. "The community member was so relieved that he started crying. He came for the vaccine, and left with a zero balance," Contreras says. ■

COMING IN FUTURE MONTHS

- Some patient encounters require supervisor involvement
- Patient access pushes registration wait times to near zero
- Same-day appointment scheduling boosts revenue
- Tactics to prevent loss of Medicaid coverage

Copay Collection Cannot Delay Care, or Hospital Risks EMTALA Violation

Patients come to EDs seriously ill, injured, and worried, often without any identification or insurance card. In addition to all these challenges, ED registrars also have to keep the Emergency Medical Treatment and Labor Act (EMTALA) law in mind when collecting copays.

"Timing is crucial, and it's most likely what gets providers into trouble," says **Edna McLain**, JD, a partner in the Chicago office of SmithAmundsen.

In general, the key is to ensure any payment request does not impede the medical screening exam (MSE) or any needed stabilization services required to address an emergency medical condition, as defined under EMTALA, says **George Breen**, JD, chair of the National Health Care & Life Sciences Steering Committee at Epstein Baker Green in Washington, DC.

Whether asking for payment is an EMTALA violation probably depends on exactly when in the ED visit a registrar makes the request. "This requires good communication between registration staff and medical personnel," McLain says. ED registrars should bring up payment or insurance only after a MSE and stabilizing treatment has been provided. This means a patient should not be asked about copays or payment during the MSE or while undergoing stabilizing treatment.

Asking for an individual's basic identification information and emergency contact information are permitted as part of the registration process.

"However, registration staff should not delay the MSE or stabilizing treatment to inquire about payment or insurance," McLain cautions.

Problems occur if registration practices delay the required MSE, medical stabilization, or transfer. "The cardinal rule to remember is that reasonable registration practices are fine," says **Douglas B. Swill**, JD, a partner in the Health Care Group at Faegre Drinker Biddle & Reath. "This generally means that staff are not pursuing financial responsibility answers and determinations while the patient who has an emergency medical condition is unreasonably delayed in receiving the MSE — or worse, stabilizing medical treatment."

If a qualified triage professional determines the patient can wait a reasonable amount of time for the MSE, then further collection of information can occur, as long as doing so does not delay the MSE.

Gathering names, addresses, and even insurance cards may be an appropriate and reasonable registration practice — again, provided it does not delay a timely MSE. Collecting copays before an MSE or stabilizing medical care happens may seem harmless to registrars, but it could land the hospital in trouble.

"It could likely subject the hospital to potential EMTALA violations — or, at the very least, a very challenging response to a federal or state survey team sent to the hospital to assess whether such registration practices violated EMTALA," Swill cautions. ■

Many Patients Worry About Hospital Bill During ED Visit

Most ED registrars probably know better than to ask for payment before a medical screening examination (MSE) is completed to avoid an EMTALA violation. However, some patients bring up the topic of money themselves. Some ask, "How much is this visit going to cost me?" or "Does my insurance cover this?"

If the answer is not too reassuring, that patient might leave to avoid a huge bill. That could be construed as an EMTALA violation. "Because of the possible deterrent effect, a helpful answer to a patient asking about insurance could be, 'You have a right to a medical screening examination and certain appropriate treatment, regardless of ability to pay,'" says **Lee Little**, JD, an attorney at Augusta, GA-based Hamil Little.

It is not an automatic EMTALA violation for registrars to ask about insurance after triage but before the MSE. However, it is a potential violation if the MSE is delayed because of it, or the patient is deterred from staying in the ED because of it.

"Sound policies, staff training, scripting, and tight practices are needed to ensure compliance," Little offers. "Some conservative hospital risk managers err on the side of caution."

They simply advise registrars not to ask for any financial information or engage in any such discussions until after the MSE is over. This includes not even asking for an insurance card or taking a $20 copay.

To avoid problems with EMTALA, Little says hospitals "should have well-trained staff, using carefully drafted

scripts, for patients who insist on discussing insurance coverage before the MSE."

In one case, a man experienced chest pains while shopping with his family and presented for screening at an ED. The registrar asked for his insurance card before the MSE and saw the plan was out of network with the hospital. The registrar informed the patient, who left the hospital without undergoing an MSE. The man later died.

"The family alleged that the hospital registrar deterred the man from receiving an MSE by telling him [the hospital] was out of [his insurance] network," Little says.

Training can help ED registrars respond to tricky patient questions on insurance coverage or cost. **Douglas B. Swill**, JD, a partner in the Health Care Group at Faegre Drinker Biddle & Reath, says registrars must be clear on these specific points:

- Do not collect money before a MSE or stabilizing treatment. "The whole point of EMTALA is to provide MSE and stabilizing treatment with or without one's ability to pay," Swill says.
- When the registrar does ask for the copay, "care must continue, regardless of whether a patient can or cannot make such payment," Swill cautions.
- Registrars also must be careful if seeking to collect from family members who accompany the patient to the ED. "Again, such activities cannot delay the MSE or treatment," Swill notes.
- ED registrars should not discourage the patient from leaving the hospital because they have no insurance, poor insurance, or out-of-network coverage.

"It is important to contemporaneously support that the hospital did not discourage the person from staying for a MSE and/or stabilizing treatment because of a patient financial issue," Swill says.

If a patient says he or she is leaving because of the hospital bill, that is a dangerous situation medically and legally.

"If the person raises the issue of cost, staff should emphasize that the hospital offers financial assistance," Swill says.

Registrars need to document any efforts made to address the patient's concerns. For instance, a registrar might make a note in the chart stating, "Gave the patient printed information about financial assistance" or "Explained the hospital's obligation to provide an MSE and medical stabilization care regardless of the ability to pay."

"In my experience, hospital staff are trained to do the right thing, and usually do," Swill says.

Chart notes showing what registrars did to encourage a patient to stay in the ED can make all the difference in defending the hospital if there is an investigation or lawsuit weeks, months, or years later.

Invariably, surveyors are going to look at the medical record to find out what happened and what could have gone wrong.

"Generally, the more information about the specific situation, the better," Swill adds. ■

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