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INSIDE

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Outpatient registration fades away: Collections are up; denials are down

Registrars become financial specialists

Shands Hospital at the University of Florida gradually is changing the face of registration and, in the process, improving the financial health of the Gainesville-based organization, says **Beverly Varshovi**, associate director of admissions.

The change started five years ago when registrars were placed in the hospital's ancillary departments, and continues this year with the roll-out of registrars to the physician offices and clinics that are not owned by the hospital, but rather associated with the University of Florida College of Medicine.

The shift away from a traditional outpatient registration department — where any patient new to the system passed through a central area — began in 1997, when a continuous quality improvement (CQI) team took a hard look at financial functions in the outpatient arena, she notes.

With the change in payer mix as HMOs became prevalent, adds **Tim Carney**, assistant manager of outpatient financial arrangements, failure to get pre-certification for accounts was resulting in large financial losses for the hospital.

"Nothing was being pre-certed on the outpatient side unless the physicians did it, and they were doing it for their procedures but not for [hospital procedures] like MRIs [magnetic resonance imaging]," he says.

The 18 or so employees who worked in outpatient registration were calling patients in advance of their appointments to get demographic information, but were not verifying accounts, he notes. "When they called patients and asked for insurance information, they were getting the layman's version, which might mean the wrong insurance or the wrong plan code."

While the inpatient side — where financial representatives had handled all accounts for many years — had a denial rate that was less than 1%, Carney says, the outpatient denial rate was closer to 50%.

Varshovi did a CQI presentation illustrating the money being lost to

outpatient pre-certification denials and the cash she believed could be collected at the point of service, she says. "I initially asked for 22 full-time equivalents to be added or upgraded [to financial representatives] and decentralized to these locations."

"Upgrading" to financial representative, Varshovi says, means that in addition to data collection, account creation, and minimal electronic verification, the employee's duties also include verification of benefits and eligibility, pre-certification, estimate of charges, point-of-service collections, and sponsorship referral. The latter, she explains, means that if the patient can't pay, the financial rep takes a credit card application or, based on the person's income and liabilities, determines if he or she is eligible for Medicaid, Medicare, Supplemental Security Income, or another aid program.

After getting approval for an eight-person pilot project that began in July 1997, she came back to hospital officials in January 1998 with the results, she adds. "They were so pleased that they asked us to roll out the program in six months, instead of the two years we had proposed."

"We had to find an additional 15 staff members — making a total of 23 — and it took us about eight months to do that," she says. "There were a number of things involved in each placement [in an ancillary department]. We were moving into clinical locations, and the people there didn't always look at it as a collaborative effort. You have to build relationships."

Despite a lack of space and clinicians' concerns that services were being delayed, Varshovi notes, the program was very successful. In 1997, point-of-service collections for her entire department — inpatient, outpatient and emergency department registration — totaled $900,000, she says. In 2001, the figure was $4.4 million.

In 1997, the hospital wrote off $3.3 million in denied payments due to lack of pre-certification, Varshovi adds. That figure was down to $1 million in 2001. Through April, pre-cert denials for 2002 had totaled only $322,000, she notes. **(See charts, p. 87.)**

Two years ago, Shands decided to take the next step in its decentralization process, Varshovi says, which started with empowering the staff of the clinics that report to the College of Medicine. "We spent last year training up to 300 staff members to issue a patient identification or medical record number so their patients don't have to go through us [to be registered]."

That process, she explains, involves creating an "MPI [master patient index] screen" with 25 data elements, including name, date of birth, race, home address, and other key elements. "They can't create a full account, because we don't want to take up space in the database with accounts that have a zero balance," she says.

The creation of this kind of account, Varshovi adds, signals that the person is known to the system but has not used hospital services.

Up until this point, she notes, any patient new to the Shands system — even if no hospital services were involved — had to go through the hospital registration process to get a medical record number.

"Before, there were 128 people who could issue a new ID number, and they all reported to me," Varshovi says. "Then there were 300 additional people who could issue an ID, and they didn't report to me. We want to see if we had an increase in duplicate medical record numbers as a result."

Although her department will track the accounts — following up if there is a match on three or more data elements — with the support of the information systems department, she notes, no results were available as yet.

Reducing the number of "superficial" accounts and data collection by 50%, she explains, allowed the remaining outpatient employees who had been doing telephone registration to become candidates for financial representative positions in the next phase of the decentralization process.

Those employees — after passing an eight-week training session to upgrade their skills — became eligible to perform the same functions in the physician clinics that their outpatient colleagues did in the ancillary departments, Varshovi says.

Putting financial representatives in the clinics, she adds, will relieve the long lines that sometimes

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Results of Shands' Decentralization Process

Revenue Cycle Indicators (Weekly Averages) July 1998 – June 2001

	Fiscal Year 1999	Fiscal Year 2000	Fiscal Year 2001
Overall Denial %	6.3%	2.6%	2.4%
First Pass %	39%	48%	53%
Unposted Charges	$548,806	$262,073	$120,658
Precert Denial Write-Offs	$28,181	$39,628	$17,998
Discharged, Not Final-Billed	2,399,102	982,268	713,860

Annual Performance Indicators July 1998 – June 2001

	Fiscal Year 1999	Fiscal Year 2000	Fiscal Year 2001
No. of Accounts Created	356, 043	356,967	380,499
Point-of-Service Cash	2,789,015	3,249,076	4,477,174
No. of Precertifications	31,883	48,685	69,793
No. of Insurances Verified	149,725	166,681	224,413
No. of Written Patient Acknowledgements	77	132	278

Source of both charts: Shands Healthcare, Gainesville, FL.

occur when patients from several different specialty clinics line up at the lab to receive services. "We wanted to place [financial reps] at the site where the tests are ordered, if the volumes warrant it."

At the dermatology clinic, which orders two tests a day, the placement isn't needed, she notes. But a surgical specialty clinic, or a pediatric clinic, warrants two financial specialists, Varshovi says.

Another benefit of having financial reps on site at the clinics, she points out, is that they can try to keep patients from having tests done at laboratories that are not included in their insurance plans.

"If we can be in the clinics where the tests are ordered, we can tell the patients where they need to go, and educate the physicians as to what the [managed care] contracts call for, so they will stop sending patients to [labs] where contracts are not honored," she adds.

Shands began placing financial reps in the clinics in May 2001, Varshovi says, and was to finish the process in July 2002.

Part of the "education piece," she notes, has meant serving in an advisory capacity to physicians, notifying them that Shands will not be paid if it performs a particular test. "You have to understand, this is a culture in which physicians have been king and can do what they want, and suddenly we're telling them they can't move forward."

A success story

One of Varshovi's favorite success stories resulting from the physician education effort has to do with a patient who was referred to Shands' nuclear medicine department for testing. The drug that was to be used cost $1,200, she says, and the procedures another $3,600.

"When the [financial specialist] saw that it was self-pay, she looked for other options," she adds. "She explained to the physician that the patient would have to pay for this, and that it would take

a long time [to do so]."

The physician said that while the expensive drug was necessary, a series of less expensive tests could be substituted for the ones he had originally ordered, she says. In the end, the cost for the tests was reduced from $3,600 to $800.

"The physician would never have known [that the patient would have incurred the expense] if we hadn't told him," Varshovi adds.

The education process is ongoing, she notes. "There are still things [physicians] don't understand — how they can be contracted with a payer when the hospital is not." And sometimes, the physician will elect to have tests done at Shands regardless of payer considerations, she adds

"Our medical records are on-line, so any of the tests done here, [physicians] can pull up on-line," she adds. "They send a patient to X-ray, and two hours later, they can see the results. If they send the patient [to another facility] they can't do that."

In such cases, Varshovi says, the financial reps inform patients and have them sign a waiver. "They need to know up front, so they can work out a way to pay."

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New admissions unit targets ED overcrowding

Clinical decision making to be enhanced

Surrounded by hospitals that either are being sold or closed or are merging with other health care organizations, Swedish Covenant Hospital has become — as was stated in a recent *Chicago Tribune* article — "the largest stand-alone inpatient facility in north Chicago," says **Gillian Cappiello**, CHAM, director of access services.

"What's happened with all the closures and mergers is we're growing in leaps and bounds," she adds. "When one of the closest competitors closed, our emergency department (ED) visits really increased."

An ED that often is on diversion status combined with a shortage of nurses and some technical support personnel has prompted a move toward more centralization of services, Cappiello says.

In an effort to streamline admissions and turn around rooms more quickly, she says, the hospital plans to begin construction around September

The end of an era for outpatient registration

Department at Shands closes after 30 years

The end of June 2002 was the "drop-dead date" for closing down outpatient registration as it had been known at Shands Hospital for some 30 years, says **Tim Carney**, assistant manager of outpatient financial arrangements.

The action is the culmination of a five-year decentralization process in which registration staff were upgraded and disseminated to the Gainesville, FL, organization's auxiliary departments and administrative personnel at Shands' physician clinics were empowered to create minimal patient accounts.

In 1997, when the process began, there were about 18 employees in the outpatient registration, Carney says. Three of those handled "walk-ups" — patients who had not been preregistered — and the others called patients in advance of their appointments to get demographic information, he adds. Including management personnel, the department's staff numbered in the low to mid-20s, Carney notes.

Now, he says, the staff for outpatient financial arrangements totals 62, including two assistant managers and two coordinators. Along with closing the traditional outpatient registration department, Carney says, they want the title of "registration" gone. "It's not a complete enough word anymore," he explains. "All of these people are verifying and making financial arrangements, just like on the inpatient side."

On May 6, he says, the outpatient registration department shut its doors for walk-up business, while continuing to have staff answering telephones. "When you've had something for 30 years," Carney adds, "you don't just stop. Even though we went to every manager and director [with the notice of closing], it doesn't mean we got to everybody in an organization with 10,000 people."

One of the discoveries made after the May 6 closing was that the "stragglers" who still were calling outpatient registration were using it for the wrong things, he points out. "Oral surgery [patient accounts] always should have been going to the inpatient side, but [physician staff] were calling outpatient registration and getting accounts created," Carney adds. "Psychiatry has been calling outpatient registration for EEGs [electroencephalograms], which also should be run through the inpatient side."

Although the accounts were not getting verified, they "fell into a big pile" because they were not high-dollar accounts, he notes.

People who call the outpatient registration number now will get a recorded message telling them that patients may register at the site of service, adds **Beverly Varshovi**, associate director of admissions. The message also will include numbers to call for people who need to reschedule or who have questions about their bill. ■

2002 on a new observation / express admission unit adjacent to the ED.

The unit will serve a dual purpose, she notes. "Patients who are now just admitted to the nursing unit from the ED can go through this unit first. It will act in some regard as a clinical decision unit." For cases in which the physician needs to rule out a myocardial infarction, for example, the unit will have a treadmill, she adds.

"At present, some of the patients admitted to the hospital don't really need to be fully admitted," Cappiello says. "They could just stay [in the observation unit] for eight hours or so and go home. It will be close by, and will help reduce length of stay and keep beds open for patients who really need them."

The hospital already has a short-stay unit, but it is used for anyone with a stay of fewer than three days, she explains. "The model we use there is that everything needs to be done a little more quickly than in the regular medical-surgical unit. This [new unit] will take the true observation case out of the short-stay unit."

Express unit 'most exciting'

The express admission unit is "the most exciting piece" of the project, Cappiello says, from the perspective of both nursing and admissions.

On the traditional patient unit, she points out, doing an admission takes nurses away from their other duties. "It can take an hour and a half to do the admission assessment, process orders, and begin treatment."

The express admission unit will allow patients that ultimately end up on the nursing floors to be processed as transfers, Cappiello explains. "The nurse accepting there won't have to spend a big chunk of time away from regular patients, so we hope it will be easier for the units to take patients more quickly. They may call sooner to say they can accept a patient."

And, she adds, "it's certainly an admitting pleaser" in that rooms can be turned around more quickly and bottlenecks avoided. "If a room is not ready, this way the patient won't be in the lobby, but will be getting care," Cappiello says. "We won't have to tell the physician he can't send someone right away."

The only ED admissions that won't go through the express unit will be psychiatric patients and patients admitted to the intensive care unit (ICU) or the intermediate-care unit (IMCU), she notes.

There will be an effort to recruit nurses to work in the express unit who actually enjoy the process of admitting patients, she notes. "All [those nurses] will do is complete the admission assessment and do the first set of orders. There won't be several other patients all needing care."

Enhancing the process will be the institution of bedside registration, Cappiello says. "We will have devices on mobile carts in the ED and the express admissions unit."

On a typical day, she adds, there might be 25-30 patients admitted from the ED in a 24-hour period. Taking away psychiatric and ICU/ICMU patients would reduce that number by 10 or 12, she adds.

"We're anticipating there will be about 12 or 13 beds in the new unit, so if you figure we only need a couple of hours [per patient], we should be able to keep things moving," Cappiello says. "If necessary, we can keep patients in the ED a little longer, but this should help the ED overcrowding."

In the past, she says, patients occasionally have had to be boarded overnight in the ED and the recovery room because there were no beds available.

Being able to move patients through the system more quickly will please the hospital's physicians, Cappiello notes, as should the good care outcomes that are likely. In addition to such features as the on-site treadmill, every room in the unit will have telemetry, she points out.

"We will also [provide telemetry] hospitalwide and have a remote room for monitoring," she adds. "That should cut down on our transfers."

A nursing executive who is no longer with Swedish Covenant proposed the idea for the new unit, she says, and the current vice president of nursing "has taken the charge on and developed it more."

"It made a big difference at other organizations who have a clinical decision unit, such as the Cleveland Clinic, for example, to be able to make clinical decisions right there and cut down dramatically on admissions from the ED," Cappiello adds.

The idea, she explains, was that taking the patient away — albeit just a few steps away — from the busy ED environment could provide a less-hectic setting in which to consider care options.

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Pros ask: Where are the access benchmarks?

NAHAM standards due at end of 2002

Access managers increasingly are seeking reliable benchmarks against which to measure staff productivity and revenue management achievements, saying there is little or no meaningful information available.

Anxious to establish fair standards for their own employees, and to illustrate for higher-ups the strides their departments are making in cash collection and billing accuracy, they find few definitions for excellence in access management.

"We need some common-denominator standards," says **Beverly Varshovi,** associate director for admissions at Shands Hospital at the University of Florida in Gainesville. "I want to know if anybody has any *good* standards. Data that is out there is sometimes so raw that it doesn't always help me."

"Where do you find productivity measures, and how do you know what the standards are?" adds an admitting director who works for a large hospital in the Midwest and asked not to be identified because of an organizational policy. "How do you develop standards for admitting employees — number of registrations and the time frame for doing them?"

"It's always good to have an objective goal," she notes, "and when you don't have benchmarking statistics, it's subjective. It's one thing for me to

say, 'I expect every employee to do 60 registrations because that's what I think.' But if I could say, 'We fit into this category, so we should average this many registrations,' then it becomes objective."

While her admitters have to deal with the Medicare Secondary Payer letter and getting conditions of admission forms signed, she points out, "other departments are doing different things. Some of them have financial counselors, for example."

Varshovi says her organization did some management engineering and established its own guidelines for registrars.

"When we have registrars who don't verify accounts or collect cash, but who collect demographic and third-party payer data, create accounts for billing and review patient rights and responsibilities, their minimum standard is 40 registrations per day. But with financial specialists, the minimum is 20 per day," Varshovi adds.

They do everything from sponsor referrals to verification to collection. In doing "sponsor referrals," she explains, the employees look for "sponsorship" of a patient account, which might involve arranging for coverage by Medicaid, Supplemental Security Income, or another source.

"How [the guidelines] compare industrywide, I don't know, and I would like to know," Varshovi says. "I would like for the access management people to step up and say, 'We're going to define this and say what are the acceptable [comparisons] and what are the carve-outs, regarding some common elements that we all experience.'"

These "carve-outs," she notes, would have to do with such things as the degree of managed care penetration and state-sponsored coverage for a particular organization, which would affect a hospital's percentages on upfront collection, for example.

"I've talked to [access managers] at hospitals where 50% of the patients are state-sponsored," Varshovi adds. "Obviously they're not collecting from that portion of their patients."

The fact that her facility has a transfer center, with five full-time equivalents means that her department is paying for functions that are not applicable at many other organizations, she points out. Dividing the bottom-line budget by the number of admissions — a common form of comparison in the industry — wouldn't take that transfer center function into account, Varshovi adds. "If at your organization it costs $7 to process an admission, it might take $12 at mine, she says, which wouldn't be an accurate measurement of efficiency.

Some departments don't handle emergency department (ED) registrations, she notes, and some close at 7 p.m. and transfer their functions to the ED.

Developing a formula that takes into account such variations would be one answer, she suggests. "We might say, 'Plug in the number of this and this, subtract this, then multiply the number of Medicare patients by this.' It could be customized by location."

Those in the patient accounting field routinely use standards promulgated by a quarterly financial publication called *Hospital Accounts Receivable Analysis* that is put out by Aspen Publishers in Gaithersburg, MD, Varshovi says. "That data is pretty much the bible for accounts receivable management."

To her knowledge, she adds, there is nothing comparable in the access field. "You work against [your own best performance], but at some point, you have to show how you compare to others in the industry."

Standards may be on the way

The National Association for Healthcare Access Management (NAHAM) is working toward the establishment of benchmarks and best practices for access management, notes **Steven Kemp**, executive director of the Washington, DC-based organization.

At a meeting in November 2001, he says, NAHAM's board of directors identified as a strategic goal the establishment and application of metrics to the patient access continuum.

"The project's scope will be to develop a standard, measurable data set of demographic, financial, and clinical prerequisites for a patient encounter that allows for local interpretation and implementation while maximizing the patient experience," according to an article on NAHAM's web site, www.naham.org.

The organization will seek the assistance of its members in the endeavor, the result of which is expected to be available at the end of 2002, Kemp says.

Monitoring outcomes

It's important to look at and measure what happens on the back end of the billing process that is a direct result of registration initiatives, Varshovi points out.

"What I keep talking about is to continue to monitor outcomes," she says. "What is your bad

debt? Maybe you're paying a lot of people on the front end, but it's worth it because of what happens on the back end."

Among the outcomes that should be monitored, she suggests, are point-of-service cash collections and first-pass yields (bills that are able to go out electronically without being touched by human hands). "Look at pre-cert denials and unmatched charges — charges that get put through by different departments, but for which you can't find valid accounts, either because the account was never created or because something was keyed in wrong."

Through efficiencies achieved by the admissions department, she says, Shands' unmatched charges for any given week have decreased from about $1 million in 1997 to about $60,000 at present.

As her health system faces the challenge of standardizing operations at hospitals throughout the system, the director from the Midwest notes says she is looking for answers to questions such as, "How many registrars should it take to do this many registrations?" and "What's the benchmark for accuracy of the data?"

"What one hospital in the system needs isn't exactly what I need because I register 60,000 more patients than they do," she points out. Instead of just saying, "I need more employees than that," she says, she'd like some industry statistics to back her up. "Where do I go to make it more than just my opinion?" ■

Getting paid for MRAs poses access challenge

'Lack of documentation' is issue

What are access managers doing to get Medicare reimbursement for magnetic resonance angiography (MRA)? That's the question that **Gillian Cappiello**, CHAM, director of access services at Chicago's Swedish Covenant Hospital, would like for her colleagues across the country to answer.

Her facility has a number of physicians who frequently order MRAs — most commonly of the neck and head — and "a bunch of neurologists" who order magnetic resonance imaging (MRI) and MRA at the same time, for both inpatients and outpatients, Cappiello says.

It seems that the only way the MRA passes Medicare scrutiny is if surgery is anticipated, Cappiello says. "Maybe we shouldn't let any physician who isn't a surgeon order the tests, but we also have the exams ordered by surgeons that get denied."

The reason given for the denial is always that there is not enough supporting documentation, she notes. "Most of the time [with denials], it's the diagnosis that doesn't pass, but in this case, it's the lack of documentation."

"We came up with a process where physicians need to provide documentation before they schedule the MRA," Cappiello says. "We created a fax sheet to send them to check off the things they've included."

One of the items on the checklist is their office visit chart notes, she adds. "The documentation will then be reviewed by the radiologist to determine if in their opinion the test will meet medical necessity requirements."

The documentation will then be reviewed by the radiologist to determine if, in his or her opinion, the test will meet medical-necessity requirements, Cappiello says.

If the OK is given, she adds, the appointment center will call the patient to schedule the test. If not, the radiologist would call the ordering physician to either get more information — which would need to be provided in written documentation — or to decide whether to go ahead with the MRA and inform the patient he or she will need to sign an advance beneficiary notice, she notes.

Medicare's position appears to be that there is no reason for an MRA until the physician already has reviewed an MRI and a carotid Doppler study and now is anticipating there will be surgery, Cappiello says. "It seems to be for that reason, anyway, but the language in the Local Medicare Review Policy takes some reading through."

[If you have feedback on this or other access issues, please contact editor Lila Moore at (520) 299-8730 or lilamoore@mindspring.com. Gillian Cappiello can be reached at (773) 878-8200, ext. 5051 or GCappiel@schosp.org.] ■

ED-to-ED transfer not always an EMTALA violation

State law must be followed, unless it conflicts

Question: Can a patient be transferred from an intensive care unit (ICU) of one hospital to the emergency department (ED) of another hospital, based on an accepting physician's request? What if the ED receiving the patient is holding patients waiting to be admitted?

Answer: In part, the answer to this question lies with state regulations, since several states take the position that transfers to the ED from an ICU represent a transfer to a lower level of care or an abandonment of the patient, says **Stephen Frew**, JD, risk management consultant at Physicians Insurance Co. of Wisconsin, based in Loves Park, IL.

Hospitals are required to comply with their state laws and regulations, to the extent that they do not conflict with the Emergency Medical Treatment and Labor Act (EMTALA) requirements, he explains. "This requirement then makes this type of transfer a violation in those states that have the rule," he says.

Frew recommends checking with your state hospital inspector to determine your state's regulations regarding transfers. However, Frew adds that EMTALA does not specifically forbid transfers to the ED. In fact, he says recent citations suggest that if there is a long transfer or deterioration, the ED should provide a medical screening examination to the transfer patient before sending patients to the floor.

EMTALA requires that the receiving hospital accept the patient, but it does not specifically indicate who the accepting person is, says Frew. "Some states require an accepting physician in addition to the EMTALA requirement," he adds. "In the absence of state standards, EMTALA does not say where or how the patient must be accepted."

Frew emphasizes that EMTALA requires that the hospital provide necessary further care and stabilization of patients who are known to have an unstable or emergency medical condition. "These terms are defined by law and are much broader than medical terminology," he notes. "It is relatively safe to state that all patients coming from an ICU in need of a higher level of care have an emergency medical condition and are unstable, as defined by EMTALA."

The Centers for Medicare & Medicaid Services will look at whether the hospital promptly and appropriately provided necessary evaluation and stabilizing care to the transfer patient, says Frew. "If that care is rendered, it is unlikely in most states that the hospital would be cited," he says.

Question: We are a rural hospital and transfer most of our neurological, cardiac, and trauma patients. One of the hospitals makes us wait several hours for bed availability. If we have an acute myocardial infarction and an accepting doctor from the hospital, is there anything we can do to speed up the transfer process? Would it be an EMTALA violation if we sent the patient to the hospital ED?

Answer: That depends on the stability of the patient, according to **Jonathan D. Lawrence**, MD, JD, FACEP, an ED physician and medical staff risk-management liaison at St. Mary Medical Center in Long Beach, CA. For unstable patients, the receiving hospital has no excuse for delaying the transport of a patient to a facility for a higher level of care if a physician accepts the patient and the hospital has the equipment and personnel to treat the problem, says Lawrence. "This is the kind of patient that typically will go straight to the OR [operating room], cath lab, or for other acute diagnostic or therapeutic intervention," he adds.

Lawrence stresses that the admitting office or other administrative personnel should have no veto or delaying power over this type of transfer. A case could be made that any nonmedically based delay by the receiving hospital is tantamount to a refusal to accept, which may subject the receiving hospital to statutory punishments, he adds.

On the other hand, Lawrence adds that a stable patient (defined by EMTALA as one in which no reasonable expectation of deterioration is expected as a result of the transfer) may be held at the sending hospital for a reasonable length of time at the sending hospital while the receiving hospital checks on bed and personnel availability.

"There is no recognized time limit of 'reasonableness,'" he says. These patients will typically be admitted to a hospital bed without immediate therapeutic or diagnostic interventions, and it is

not unreasonable to allow the receiving hospital to assess its resources and ability to care for the patient, says Lawrence.

Contrary to popular myth, there is no EMTALA prohibition of an ED-to-ED transfer, says Lawrence. "If the receiving hospital wishes to receive transferred patients, stable or unstable, into its ED, it may do so," he notes. The so-called prohibition against ED-to-ED transfers is a business-office rule, since Medicare and many insurance carriers will not pay for a second ED visit on the same day for the same problem, explains Lawrence.

[For more information about the Emergency Medical Treatment and Labor Act (EMTALA), contact:

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Don't give up: ED copays are 'built into contracts'

Here's the managed care perspective

(Editor's note: In this first part of a two-part series on collecting copays, we discuss how much you can collect and how to do it. Next month, we give you three tips for collecting at the end of the visit.)

Many access managers who oversee emergency department (ED) registration have given up trying to collect copays, but this is a definite mistake, according to **Michael J. Williams**, president of the Abaris Group, a Walnut Creek, CA-based consulting firm specializing in emergency services. "Copay collection strategies are a critical tool needed to round out the revenue cycle for EDs," he insists.

Are you missing out?

You're missing out by not collecting copays, Williams says, since they are part of the payment assumptions built into payer contracts. "Hospitals often have inadequate or no systems in place to collect the fees we have negotiated in our contracts, namely the copays," he says.

Copays generally are $25-$50 for all managed care patients, and there is the potential to collect up to $800 at the beginning of the year when Medicare patients have not yet met their deductible, says Williams. "Only 35% of copays are paid after the ED visit," he adds.

If you increase this to 65%, you'll increase revenues by $150,000 per year, assuming you collect from 15,000 managed care patients with an average copay of $35, says Williams. Some EDs are collecting $25,000 to $100,000 per month in copays that otherwise would be written off, or for which additional costs would be incurred by mailing bills in an attempt to collect, he adds.

EDs wary of asking for money

Too often, ED managers shy away from collecting copays, fearing violations of the Emergency Medical Treatment and Labor Act (EMTALA), according to **Thom Mayer**, MD, FACEP, chairman of the department of emergency medicine at Inova Fairfax Hospital in Falls Church, VA. "However, the hospital attorneys would be the first ones to tell you there is nothing wrong with doing this," Mayer says, adding that his ED has had significant success in collection of copays.

Copays should be only collected after the patient has been fully medically screened, Williams notes.

Some EDs report unsuccessful experience with copay collection. "This is something we have struggled with," says **Richard Eckert**, MD, medical director of emergency services at University Hospital in Augusta, GA. Instead of doing a medical screening examination at triage, patients are taken directly to treatment rooms where a physician sees them and a disposition is made, says Eckert. "The chart may be made with the financial data before the patient is seen, but since we have the policy that all are being seen and fully evaluated, this does not violate any EMTALA concerns," he adds.

The complete chart is made either before or during the medical evaluation process, he says. No copay questions are asked up front. He adds that the ED tried to implement a copay collection process at discharge. "This required additional personnel that we did not have to spare," says Eckert. "Also, very rarely could we collect anything. The patient response was almost always 'Bill me.'"

Here are things to consider about collecting copays:

• **Use "tools" to encourage payment.** Williams

recommends use of the following to encourage a patient to pay at or near the time of service:

— **Promissory notes.** These are contracts signed by the patient or financially responsible party provided at discharge.

— **Self-addressed envelopes.** If patients don't have the copay, Williams recommends providing a self-addressed stamped envelope with the patient's account number on it. "If the ED has a financial incentive for point-of-service collections, this payment gets credited to them," he says. "Staff are usually highly motivated to pursue this."

— **ATMs and/or credit card machines.** A strategically located ATM machine in the ED is a powerful incentive for patients to settle copays, suggests Williams. "This can be a freestanding machine or a little credit card machine at the desk," he says. "It's hard for a patient to ignore or avoid this payment option if they have their ATM or credit card with them."

• **Determine which group will receive revenue.** At Inova Fairfax's ED, the copay revenue is collected entirely by the hospital, reports Mayer. "We have had some talk of a 50/50 split between the physician group and the hospital," he adds. "But while it is a fair amount of money, it is something the hospital is doing with the registrar people who are hospital staff members."

• **Evaluate costs.** Eckert recommends evaluating costs if you plan to set up a copay collection system up front. "The added cost of collecting far exceeded our ability to collect," he says. "We found that it was simpler to concentrate on moving patients quickly and safely through the ED." Although most physician offices collect copays up front, you cannot do this in the ED unless a medical screening examination has been performed, he notes.

If you decide to do this, an appropriate medical person would have to be used, says Eckert, and then if no medical emergency were found, the patient would be refused further use of resources until they paid up front. "This means that you would have to send away both well-insured who didn't have a copay on them that day, as well as the indigent who doesn't pay his bills anyhow, or you would have a two-tiered system, which would be illegal," he says.

This would create a public relations nightmare for the facility and a lot of angry people within your ED, says Eckert. "I do not think that many hospitals are going to allow you to refuse further care to a paying customer," he adds.

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Court tells Medicaid it violated federal law

In what appears to be a step forward in the struggle by hospitals to get paid for their services, the Maryland State Court of Appeals ruled in late June that the state's Medicaid program violated federal law by refusing to reimburse Baltimore's Johns Hopkins Hospital for two liver transplants.

The state said the procedures were not "appropriate," but the court ruled that "medical necessity," not whether a procedure is "appropriate," is the federal standard, according to a report in the on-line news service *AHA News Now*.

The procedures cost $264,000. Denial in one stemmed from the case of a 10-year-old boy with end-stage liver disease who had two liver transplants — paid for by the state — in 1992. When the boy fell ill again in 1995, the state refused a third transplant after an evaluation showed "risk-taking behaviors" by the boy, including selling drugs and drinking alcohol. The second case involved an unknown cause for liver failure in a young girl. The boy is still alive, but the girl died one year after her transplant. ▼

Sentinel-event cases don't just happen in ED

While hospital emergency departments (ED) are the source of more than half of all "sentinel event" cases of patient death or permanent injury due to treatment delays, such problems can occur in any hospital unit, says the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Of 55 reported cases of delays in treatment included in data cited in a recent JCAHO sentinel event alert, 29 were ED-related, while 26 cases originated in hospital intensive care units, medical-surgical units, inpatient psychiatric hospitals, freestanding and hospital-based ambulatory care services, the operating room, and in the home care setting.

Of the 55 cases of delays in treatment, 52 resulted in patient deaths. For more information, go to the organization's web site, www.jcaho.org. ▼

New guide published for AHA billing project

Officials with the Patient-Friendly Billing project, a two-year effort aimed at making health care bills more clear, concise, correct, and patient-friendly, announced an upgrade of their web site, www.patientfriendlybilling.org.

In other news, the Healthcare Financial Management Association (HFMA) and the Medical Group Management Association (MGMA) have published a guide on the issue for medical practices to accompany the one already published for hospitals. HFMA and the American Hospital Association (AHA) initiated the project in 2000. ■