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Avoid needless ICD-10 claims denials
Act now to update access processes

Coding will become more complex

Two major areas of concern for the switch to ICD-10 are medical necessity and preauthorizations, according to **Susan Hoyle**, CCS, coding manager at Mission Hospitals in Asheville, NC. National coverage determinations, local coverage determinations, and insurance company coverage benefits will need updating, due to the increased specificity of ICD-10, she explains

Your patient access staff will be using ICD-10, the new procedural coding system developed by the Center for Medicare & Medicaid Services, as of October 2013. The new system will replace the ICD-9-CM procedural coding system used for hospital reporting of inpatient procedures.

"The risk for us will be having something not covered or paid for, due to lack of specificity needed for the codes that will meet the coverage and/or authorization guidelines," says Hoyle.

Tests such as CT scans or magnetic resonance imaging have local coverage determinations that define the diagnoses that are required before the test will be paid for, says Hoyle. "If one of those diagnoses is not on the claim, then it is does not meet medical necessity," she explains.

Rennae J. Glidden, RHIT, director of data services at HealthEast Care System — Midway Campus in St. Paul, MN, warns, "Success with prior authorization and insurance verification will depend on accurate assignment of either ICD-10 diagnosis or procedure codes requested by the insurer."

Collaboration is key

Hoyle says that patient access' biggest challenge will be getting the codes needed to determine if a case will meet criteria for coverage or preauthorization.

"Training the patient access staff to know what additional information is needed to determine the most accurate codes will be critical," she says.

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Working closely with coders and physician offices will be essential to the success of the patient access team, adds Hoyle. *(See related stories on educating staff and physician offices, p. 39, and revamping technology in your department, p. 39.)*

Hoyle says Mission Hospitals' ICD-10 program is composed of several teams across the health system. "Each team is working to identify the impact of ICD-10 in their area," she says. Right now, the department is identifying processes, software, and personnel that will be impacted, says Hoyle. "We are evaluating additional functionality in current systems that could be used by Scheduling and Patient Access, to enable a successful transition," she says.

Marsha Kedigh, RN, MSM, director of admitting/ED registration/discharge station/insurance management at Vanderbilt University Hospital in Nashville, TN, is expecting an initial slowing of work flow in her department's pre-admissions processes. "This is due to the staff learning curve," she says.

The processes of determining the reason for admission, determining inpatient or outpatient status, as well as the scheduling process for inpatient and outpatient procedures will be affected, adds Kedigh.

Avoid claim errors

Patient access staff will be working with a new set of diagnosis codes that have increased in length by two characters and which now contain alphanumeric characters, explains **Jeffrey Smith**, RN, MBA, CPC, a New York City-based manager at Accenture Insight Driven Health, a management and technology consulting company.

Claim errors could result if staff members are processing any code information that appears on a bill from lab or radiology, cautions Smith. "You will need to look at the billing process. Make a determination if any codes entered upfront end up on the bill. There could be some," he says.

There are about 14,000 diagnosis codes currently, says Smith, and this number will increase to about 68,000. Medical necessity checks could become more involved, he adds. "There will be a lot more detail to sift through," says Smith. "The expectation is that the new granular diagnosis codes will be incorporated into the medical necessity. That would increase the complexity."

SOURCES

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Access technology will need revamping

Now is time to get involved

Your current systems will need to be remediated if they will be used to check medical necessity for ICD-10 standards when they are implemented in October 2013, says **Jeffrey Smith**, RN, MBA, CPC, a New York City-based manager at Accenture Insight Driven Health, a management and technology consulting company.

Patient accounting and registration systems will need to be upgraded to accept the increased field length of diagnosis codes, he explains.

Third party web-based systems for obtaining pre-authorizations and certifications will need to be updated to meet ICD-10 standards, along with ancillary systems used by lab and radiology, adds Smith. "Providers are starting to gear up and put together their IT folks. Patient access directors should be involved," he says.

Smith gives these recommendations to prepare:

• Inventory all third party systems used in the scheduling/registration and authorization process.

"Sometimes systems aren't all fully integrated," notes Smith. "It is a question of where you are doing registration and scheduling. Some systems might fall outside patient access, like lab or radiology."

Even if staff are not capturing the diagnosis code, says Smith, the systems still might need to be remediated if they are working in areas where scheduling is done. "If they are doing any checking for medical necessity, that clearly needs to be identified," he says.

• Determine timetables for upgrading systems.

"If you have a third party system that is utilizing diagnosis code information that is being captured at the time of registration, you need to know when that vendor is going to have that system ready for ICD-10," says Smith.

While this task probably will be handled by members of the IT staff, they might not be aware of all the systems patient access is using to process diagnosis code information, Smith adds.

• Examine all patient access workflows to determine whether ICD-9-CM diagnosis codes are utilized and processed.

"You will probably need to flow out in detail all the workflows that involve the handling of the diagnosis codes," Smith says.

Identify when data is coming in from third parties, such as any paper requisitions from community physicians, says Smith. "If you are processing any diagnosis codes from these, there would potentially be an issue with ICD-10," he says. "If you are receiving an inaccurate and incomplete diagnosis and you are trying to determine medical necessity, follow up with those particular provider offices."

Consider web-based applications used in your department, because payers might have certain systems where diagnosis codes are entered, says Smith.

Systems upgraded

Marsha Kedigh, RN, MSM, director of admitting/ED registration/discharge station/insurance management at Vanderbilt University Hospital in Nashville, TN, is discussing the creation of a web-based tool for staff to use as a quick reference, with a list of the top 50 conditions and 25 procedures. "It also has a listing of payers which will require ICD-10 codes," she says.

The department is upgrading its registration system to expand the fields to accept the longer code and increased volume of codes and upgrading internal insurance web sites used by staff to assist with coding, says Kedigh.

The emergency department's electronic whiteboard houses the ICD-9 codes and also will need upgrading, adds Kedigh, as the ED physician attaches the appropriate code to the patient via the whiteboard based on diagnosis.

Susan Hoyle, CCS, coding manager at Mission Hospitals in Asheville, NC, says that staff will use an encoder to provide the ICD-10 codes, based on the verbiage provided by physicians. "Patient access will utilize a medical necessity checker to verify that codes meet criteria for coverage for Medicare," she says. ■

Educate yourself, staff, and physicians

Because the prior authorization process occurs well in advance of a service, your Patient access staff will need to be prepared for ICD-10 well before the Oct. 1, 2013, implementation date, warns **Rennae J. Glidden**, RHIT, director of data services at HealthEast Care System — Midway

Campus in St. Paul, MN. Use these strategies:

• To educate yourself:

Glidden says that you should be participating in ICD-10 training, including audioseminars and inservices offered within your facility. "Partner with your health information management coding personnel as you go live on ICD-10," she says.

To prepare for ICD-10, Kedigh has participated in several webinars from the Healthcare Financial Management Association (HFMA). *(To learn about upcoming events, go to www.hfma.org. Select "Education & Events" from the top bar. Select "Online Learning" from the left bar and then "See a listing of current webinars offerings.")*

• To educate staff:

Your patient access personnel will need much more in-depth knowledge of coding than they have with ICD-9, according to Glidden. "This is because of the complexity and specificity of ICD-10," she says.

Patient access departments will be faced with using a "robust coding system," says Glidden. "This is likely to test their knowledge of medical terminology, anatomy, and physiology," she says.

First, identify all staff who work with diagnosis codes, and determine their required level of knowledge, advises **Jeffrey Smith**, RN, MBA, CPC, a New York City-based manager at Accenture Insight Driven Health, a management and technology consulting company. "Education is the biggest challenge," he says. "Staff will need to know the code structure will change. It's going to look a lot different."

If staff members are contacting providers or discussing any kind of diagnosis information with payers, those individuals will need more training, says Smith. "This needs to be done two or three months prior to the implementation," he adds.

• To educate provider offices:

In addition to your own staff, physician office staff will need education because ICD-10 affects the scheduling process, says Kedigh.

This process will be a challenge for coders and patient access staff alike, says Glidden. "Terminology in ICD-10-PCS often does not match what physicians are typically saying," she explains.

Susan Hoyle, CCS, coding manager at Mission Hospitals in Asheville, NC, says, "Since ICD-10 codes are more specific, we'll need to ensure the physician offices provide as much detail as possible. We are planning to do a lot of physician education during the year prior to implementation."

A physician advisor is assisting with physician education regarding documentation, says Hoyle, and he will continue to take a lead role in ICD-10 preparation.

In 2012, the department's encoder and clinical documentation improvement tools will provide information to coding staff, says Hoyle. This information will explain the documentation that will be needed for the added specificity for the ICD-10 codes, while staff members still are using the ICD-9 codes, she says. "We are also beginning to look at the opportunities we may have to use prompts or drop down boxes for our physicians, as we build our electronic progress notes" in the electronic health record," says Hoyle. ■

Payer auth requirements grow — Keep up to date

Take a proactive approach

With payer requirements becoming more numerous, patient access departments face an ongoing battle to keep staff current.

"Keeping staff apprised is always a challenge," says **Catherine M. Pallozzi**, CHAM, CCS, director of patient access at Albany (NY) Medical Center Hospital. "We keep a matrix for radiology services requiring pre-authorization on our intranet site, for both patient access and radiology to view."

Other payer requirements are announced via staff meetings and e-mails, she says. "It is an area that we will continue to focus on. Every denial is an opportunity," she says.

Pallozzi says that while she has had a couple of HMOs relax their authorization requirements recently, others have increased the number of services requiring authorization. "Observation status is on the increase in our inpatient population," she notes.

The biggest challenge is keeping all ancillary departments and physicians apprised of the changes, she says. "Quite often, it is the physician's office that additional information is needed from," says Pallozzi. "We do not have a centralized scheduling process, so ensuring that ancillary departments are fulfilling all payer requirements is most critical." (See story on working with provider offices to obtain authorizations, p. 41.)

To keep ancillary areas and practices apprised of updates, Pallozzi reaches out directly to the managers with "one-on-one communication." Staff

members in patient billing services make a point of sharing any denial or provider fault information with patient access staff, says Pallozzi, "and we do try our best to be pro-active in education."

Training opportunities

Patient access services at University of Utah Health Care in Salt Lake City is seeing an increase in authorization requirements, says Adrienne Pinelle, CHAA, manager of the preauthorization team.

This increase includes procedures and services that previously did not require pre-authorization, as well as additional clinical documentation to demonstrate patients are meeting criteria for certain services, she says. "Our contracting department keeps us up to date when there are new authorization requirements being added during contract renewals," says Pinelle. "We make sure we communicate the new requirements to the authorization team."

Printed and electronic versions of the new requirements are shared via e-mail or discussions in staff meetings, says Pinelle, and she then monitors claims denials for any errors that might have slipped through. "From there, we can determine if it is a training opportunity with the team or if we need to make changes to our processes," says Pinelle.

SOURCES

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Work with providers to obtain needed auths

Staff are in difficult position

It's taken a collaborative effort between patient access and provider offices to navigate the challenges of prior authorization and payer requirements, while continuing to give patients an excellent experience, says **Adrienne Pinelle**, CHAA, manager of the preauthorization team for patient access services at University of Utah Health Care in Salt Lake City.

The biggest challenge, according to Pinelle, is the turnaround time that it takes for services to be authorized. "Our medical providers' goal is to provide the best treatment and care possible," she says. "They want the patients scheduled for services as soon as there is availability on the schedule."

A patient might be scheduled for surgery in three days, notes Pinelle. In this case, she explains, patient access staff are put in the difficult position of informing the physician and patient that the insurance company will require two weeks to complete the review prior to authorizing payment. "We do our best to work with the departments to keep the provider offices up to date with certain payer requirements," says Pinelle. In this way, services can be scheduled to allow for enough time to complete authorization requirements, she says.

Stay in close contact

Pinelle's staff stays in close contact with the various departments that tend to have significant amounts of services that require pre-authorization or other time-consuming payer requirements. Staff are able to obtain the necessary documentation proving the patient meets the criteria for the procedure, she says.

"University of Utah Hospital is a teaching hospital with new and innovative procedures that are not performed at other facilities," she notes. "Procedures that are not well known or common can be a challenge."

Pinelle says that in these cases, communication and teamwork become especially important. For example, the Cardiology Department has a unique cardiac ablation protocol that is not available elsewhere, she says, but it contributes to excellent patient outcomes. "Because this protocol falls outside of the norm, meeting payer requirements can be very challenging," she says. "We have improved the patient experience and physician satisfaction by holding meetings between our two departments."

Staff members obtained a better understanding of each area's challenges, says Pinelle. "This allowed us to share information. We created an agreed-upon workflow," she says.

Clinical areas now notify the patient access

team before the patient is scheduled, says Pinelle. This process gives staff enough time to verify benefits and authorization requirements, and then communicate that information back to the provider. "Helping the clinical team to understand the payer requirements has enabled the clinical staff to be pro-active in providing the necessary clinical documentation upfront," says Pinelle. "This has decreased turnaround time." ■

Offer staff opportunity to move within department

Encourage employees to apply

Offering large salary increases or promotions is probably not an option to improve retention, even for your most irreplaceable staff members. However, it's possible that staff might jump at the chance for a lateral move within the patient access department, according to **Sherrie Woodmancy**, service director for patient billing and financial services at University of Utah Health Care in Salt Lake City.

Woodmancy's patient access department has two tiers, with staff often coming in at the lower tier. After an employee gains some experience, she says, he or she typically applies for the higher tier.

Woodmancy has a team that is responsible for authorizations and insurance eligibility that is one grade lower than the rest of her staff. The higher tier has responsibilities for admissions, bed placement, financial counseling, ED registration and discharge, and transplant-related functions, she says. If there is an open position, staff members are given preference over someone from the outside, adds Woodmancy. "Staff are free to apply for open positions within the department at any time, as long as they are in good standing with the department and have been in their current role for at least six months," she says.

When there is a vacancy in either tier, the position is posted, says Woodmancy. Usually, positions in Tier 1 are filled from the outside, she says, and positions in Tier 2 are filled with someone who is in a Tier 1 position in the department. "Additionally, some of my supervisors have been promoted from a Tier 1 to Tier 2 to supervisor and even to a manager," says Woodmancy. One current manager started with an insurance verification position, was promoted to a financial counselor, became a supervisor over the Tier 1 team, and is now a manager over financial counseling and ED registration.

"She is young, bright, and very successful, and one of my best managers," says Woodmancy. "Part of the reason why she is successful is that she fully understands what goes on at the staff level. That is very effective in process improvement projects."

Offer flexibility

Woodmancy says that occasionally, staff members want to change roles because of factors in their personal lives, such as school schedules conflicting with their work schedule. In this case, she says, "we try our best to meet their needs. We do offer flexible schedules where we can."

The Tier 1 staff can begin work as early as 7 a.m. and as late as 9:30 a.m., says Woodmancy. "Just for that very reason, they may choose to stay where they are because it fits with family life," she says.

When staff members move from one role to another, they inevitably gain more knowledge and experience, which is good for the department, says Woodmancy. "We have regular discussions about different roles within the department," she adds. "We will allow staff to shadow another staff in a different role if they are interested."

SOURCE

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Timing is key — Obtain accurate data in the ED

Obtain information in patient's room

Sick, upset, and distracted patients often gave inaccurate or incomplete information to registration staff in the ED at Bronson Methodist Hospital in Kalamazoo, MI, notes **Tina Nadrasik**, the department's Patient Access manager. This problem sometimes resulted in claims denials, she adds.

ED registration staff now use a new process to obtain demographic or insurance information from admitted patients, says Nadrasik. If a patient is going to be admitted from the ED, a verifica-

tion staff person doesn't ask for this information while he or she is still in the hectic, noisy ED, she explains. Instead, the staff person waits until the patient is up on the floor in a room to review the information, she says.

"We talk to them in an environment that is more patient-centered and more relaxed than the ED," says Nadrasik.

Patients are more likely to listen carefully to the questions from the staff and to correct outdated addresses or telephone numbers, says Nadrasik. "In the ED environment, we don't always get that," she says. "The focus is more on the patient's medical needs."

A pilot was done in ED registration for 30 days, using the new process. "We found that we got better information," reports Nadrasik. "By the time they have gotten to the room, patients are more informed of what is happening to them."

For example, ED patients sometimes had Medicare as secondary payer insurance, and this information often wasn't being captured, says Nadrasik. "A lot of times, all the patient would tell us in the ED was that they had Medicare," she says. "Once they got up to a room, they would tell us, 'By the way, I have this too.'"

Often, registrars are able to obtain important details or make necessary corrections just because patients are calmer and not in pain, Nadrasik says. "During the pilot, we were able to make corrections to a piece of the demographic information on 18% of admissions," she reports. "It wasn't always the wrong insurance — it may have just been a cell phone number — but that information is important for follow-up."

Verification team

In the ED's previous process, says Nadrasik, a single person performed all of the verifications.

"She did all the direct admits and all of the admits from the ED," she says.

The verification person was swamped with work on Mondays because of all the admits over the weekend and would spend the rest of the week trying to catch up, says Nadrasik. A verification team was created to perform real-time verification of data, she says.

"Having a second person in there doing real-time verifications really helped," she says. *(See related stories on other changes in the ED's registration process, right, and relationships with clinical staff, p. 44.)*

SOURCE

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Changes streamlined ED registration process

The ED verification staff, registration staff, case managers, emergency nurses, and a group of patients joined together and brainstormed ideas at Bronson Methodist Hospital in Kalamazoo, MI, with the goals of reducing denials, obtaining a better understanding of each other's roles, and obtaining accurate demographics, says **Tina Nadrasik**, patient access manager over the ED. Here are three areas that were identified:

• Surges in patient volume were causing delays.

"There is only room for three computers up there, with a nurse, the registration staff person, and a greeter," explains Nadrasik.

When a patient comes to the ED, the registrar obtains a name and date of birth and lists the patient on the tracking board, says Nadrasik. "Then we immediately step aside, and the patient goes to the triage nurse," she says. "Another nurse does a more in-depth evaluation, as to where the patient needs to go from there."

During volume surges, she says, registrars can see only one patient at a time. To reduce delays, a second registrar is now contacted by wireless phone when a certain number of patients is waiting, says Nadrasik.

• Registration staff and financial counselors lacked understanding of each other's roles.

The financial counselors have detailed knowledge of Medicaid and other programs, which allows patients to get started with the financial assistance process sooner, says Nadrasik. When this information was explained to registration staff, they realized that there was a great deal of helpful information that patients could provide to financial counselors upfront, she says.

The ED verification staff and financial counselors were given laptops, pagers, and cell phones, and they met each morning, says Nadrasik. "They would figure out their day and which patients are going where," she says. "Then, they would round up on the floors and do the verification."

As a result of this new process, says Nadrasik, "we have more of an understanding of each other's roles. We make sure that before we refer an account out to a third party vendor, there really isn't anything we can do to help that patient."

• Patients often qualified for assistance, but this qualification wasn't determined until later in their hospital stay.

Financial counselors previously were considered more of a "back end" function, but bringing them into the loop helped improve communication between the front and back end, says Nadrasik.

For example, the financial counselors help patients start filling out their Medicaid applications right away, she says. "We are connecting them with the right people sooner," says Nadrasik.

If patients are found to be self-pay, staff are able to immediately contact a third party vendor that the hospital contracts with and obtain them assistance sooner, she says. "They can see the patient while they are here in the hospital and help them to fill out the paperwork," Nadrasik says. "Patients appreciate the face-to-face interaction, instead of doing a lot of phone calling after the fact." ■

Improve relations with ED clinicians, managers

The secret to any process improvement in the ED is the relationship that your registration staff have with the clinical staff and management, according to **Tina Nadrasik**, patient access manager in the ED at Bronson Methodist Hospital in Kalamazoo, MI.

"I have a good relationship with the ED manager and the unit coordinators," she says. "We often help each other identify processes that need improvement and work together to accomplish this."

Recently, it was noted that there often were misunderstandings between the verification staff and the case managers on the floors, says Nadrasik. "There was a need for better communication," she says.

Registrars often would put notes into the computer system that case managers misconstrued, and vice versa, says Nadrasik. "Often, case managers and verification did not understand what each other was trying to say," she says. "They did not talk the same language."

Case managers lacked understanding of "who does what job" in the verification office, she adds.

The case managers came to realize that in fact, the "urgent verification phone line" they were using consisted of a single person, as opposed to a whole team of people waiting to answer their phone call, Nadrasik says. "Case managers wanted to have less wait time on pending accounts, and more accounts with correct primary care physician information," she says. "One of their goals is to make sure we have that right the first time."

Registrars now use a central fax number with a designated person to contact, which eliminated delays in figuring out who to talk to, says Nadrasik.

Timing is better

Often, ED registrars would wait until a certain patient was seen by a physician to enter the treatment room, only to find the patient already had left, says Nadrasik.

The hospital's registration staff is decentralized in the units, she adds, so ED registrars work alongside the ED clinical staff. "Most of the time, before a patient is discharged, a ED nurse will let the registration staff know 'I'm discharging room 23,'" she says. "There is good communication."

To get the timing even better, a second initiative is being piloted with a registrar working in the ED using a mobile cart, says Nadrasik. "The registration person can see when the physician leaves the room or that the patient was taken out of the room," she says. "None of this would be possible without a good working relationship between registration and the ED staff." ■

Is your self-pay patient eligible for charity or not?

You might uncover insurance

As self-pay patients continue to rise in number, you'll need effective strategies for screening these individuals for charity eligibility.

"You have to do a good job of screening to see if they have coverage or eligibility under a governmental program," says **Michael S. Friedberg**, FACHE, CHAM, associate vice president of patient access services at Apollo Health Street, a Bloomfield, NJ-based developer of financial and IT solutions for healthcare organizations, a Bloomfield, NJ-based consulting company working with healthcare organizations, and author of Staff Competency in Patient Access. "To me, that's all part

of a good process and doing a good job."

Friedberg says that all self-pay patients should "immediately be screened against your state's Medicaid program. If there are any patients that are over 65 with a social security number that you are not checking for Medicare, shame on you."

Friedberg says that when time permits, checking the system for existing prior visits paid by insurance is another technique that can be effective. "In many instances, patients will have multiple medical records within a provider's system," he explains. "Depending on the accuracy of the registrar, one record could be registered with self-pay and another with insurance."

Likewise, says Friedberg, a correction might be made after registration because a patient was discovered to have insurance, but the registrar might not pick up the correct patient.

Time is limitation

"Unfortunately, in patient access, there isn't always time for this," says Friedberg. "You have to make sure that you keep things moving, but you can also uncover insurance."

He recommends meeting with your patient accounting team and asking if they are finding insurance or Medicaid coverage on self-pay patients.

There always will be cases when a staff member discovers a patient's insurance later in the process, due to the lack of consistency of carrier database updates, says Friedberg. "But what constitutes too much? That is the hard part," he says. "If you have a vendor that is doing this work, look at the accounts where the vendor is uncovering insurance, because that's a direct reflection of how well you are doing."

If you learn that "too much" insurance is being found, you should analyze two primary items, says Friedberg. First, he says, look at sample accounts to determine what type of insurance is being uncovered and also in what area and on what shift. Secondly, Friedberg advises reinforcing procedures to be sure that a proper interview is being performed at the time of registration.

"In many instances, errors made in the registration process point back to a poorly done interview," says Friedberg. "A focus on the interview process will yield improvement."

SOURCE

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Taking on collection role can be a help to patients

Culture change is necessary

When **Joan S. Braveman**, director of patient access and financial services at Tallahassee (FL) Memorial HealthCare (TMH), started point-of-service collections in her department about five years ago, she encountered a lot of resistance.

"It was not met with open arms. It was contrary to a lot of people's philosophy of what a hospital was," she says. "One supervisor said to me directly, "I'm not going to ask my patients for money. We're here to take care of people, not squeeze money out of them.'"

At the time, the supervisor was collecting about $10,000 a month on average. Over a year's time, this amount increased to $22,000 and is now at $52,000, says Braveman. The supervisor was extremely pleased with his progress, says Braveman. She attributes the change in his attitude to "a lot of culture change — not just with the community, but also the staff."

The supervisor realized that patients actually appreciated being told what they'll owe, as patients have become accustomed to being asked for money upfront, says Braveman. "People come in with a credit card out, ready to pay, or a check already made out," she says.

When making rounds in her department, Braveman often heard her staff saying to patients, "Your copay today is $100. Do you want to take care of that today?"

'If someone asks you if you want to pay your bill now, it's very easy to say, 'No thank you,'" says Braveman. "Patients frequently stated, 'TMH always bills me afterward.' So we've eliminated that language."

Staff now say, "Your copay today is $100. We accept cash, check, or credit card. How would you like to pay?" says Braveman.

Opportunities for patient

If an uninsured patient is scheduled for a service, staff contact this individual ahead of time, says Braveman.

"We look at opportunities for the patient," she says. "There are certain questions that staff ask, to see if the patient would qualify for Medicaid."

Braveman gives the example of a woman scheduled for a total hysterectomy. "Typically, there is going to be cancer involved. The patient will need some long-term treatment, whether radiation or chemotherapy," she says. 'In that case, we start a charity application file for them."

Braveman has had several patients bring in documentation before their surgery, including tax returns, unemployment statements, or other requested paperwork, to determine their eligibility for assistance. "We have found that it gives patients peace of mind. Instead of worrying about how much debt they are incurring, they can just focus on the hospital taking care of them," she says.

Staff inform any recently unemployed patients that he or she still might have time to apply for COBRA, says Braveman. "They would rather pay the $300 or $400 monthly premium than the $50,000 hospital bill," she says. "We've had this experience already a number of times."

One patient lost her job in late September and came to the hospital in early November, and she was surprised to learn she still was eligible for COBRA. "We helped her to call her former employer to get the paperwork sent again to be submitted," says Braveman. "This stopped the woman's insurance from having been terminated, so she was not without coverage" *(See related stories on self-pay policies, p. 47, and educating patients on their coverage, right.)*

SOURCE

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Are patients confused by coverage? Educate

Misunderstandings are common

Patients might have bought an insurance policy with lower premiums and higher deductibles, but lack understanding of what those mean. This part of the job is one of the hardest for patient access staff, according to **Joan S. Braveman**, director of patient access and financial services at Tallahassee (FL) Memorial HealthCare.

"We have seen a policy that has a $10,000 deductible," she says. "People may hear that, but it's not until you say to them, 'Your insurance company will not pay a penny until you pay $10,000,' that it sinks in. We have actually seen an increase in bad debt on patient liability because of that."

Braveman says that she believes insurance companies do their members a disservice by failing to educate them adequately. "A lot of times, people don't truly understand that they have to pay that amount out of pocket before their insurance kicks in," she says.

Staff members often are put in the unpleasant position of educating staff about their insurance coverage, says Braveman, and they find it hard to be the bearer of bad news. In general, she says, patients are turning to Access staff to be more informed about their coverage and responsibilities.

"In the old days, everybody had a Blue Cross type of policy and a 20% copay. You knew you would have to pay for 20% of whatever Blue Cross allowed, and that was it," says Braveman. "Now every single plan is different, even within a single payer, based on who your employer is."

Patients are taking more initiative to learn what they will owe, reports Braveman. Recently, she received a call from a case manager working with a patient recently diagnosed with cancer. "He will be needing radiation treatment and wanted some idea of how much he would owe out of pocket," she says.

Looking forward, Braveman envisions a time when this information would be more readily available to patients directly through the hospital's web site. Ideally, she says, patients would be able to put in a procedure code which would tell them, based on their plan, how much they will owe. "That's many light years away," says Braveman. "One of the biggest challenges is that patients don't know the correct codes. It can get very technical, with different codes for a CT scan for the brain or abdomen, or with or without contrast." ■

Access has 'very liberal, very fair' self-pay policy

Discounts automatically given

Joan S. Braveman, director of patient access and financial services at Tallahassee (FL) Memorial HealthCare, says that her department has put

a "very liberal, but very fair, uninsured payment policy in place."

"We looked at our three best contracts and took an average of them," says Braveman. "Anyone who has no insurance at all is going to get the same discount that we give to an insurance company."

There was a perception that hospitals were being unfair to uninsured patients by not offering them the same discount that insurers received, Braveman explains. "We have a policy in place where every single uninsured patient gets what we call an uninsured adjustment, just like we have Medicaid adjustments," says Braveman.

The hospital's discount policy is a sliding fee scale based on total household income and total number of dependents in the household, says Braveman. "So someone who is making a decent enough living, but has eight children, might still be eligible for some part of the bill to be discounted," she says.

The automatic uninsured discount is applied to the patient's bill before it ever goes out the door, says Braveman. "So the very first time the patient sees a statement from us, they can see the total charges, the uninsured discount, and the total amount due," she says.

The bill also states, "If you feel you are unable to pay this bill, please call this number to discuss other opportunities."

"We are really working with our uninsured and underinsured," says Braveman.

Deductibles are issue

One of the challenges that Braveman encounters with the underinsured population is the question of discounting deductibles. "It's something that we all struggle with. We recognize that you really shouldn't be discounting deductibles," she says.

Braveman gives the example of an employer which has negotiated a plan for their employees, with a premium cost of a certain dollar amount per month or year, based on the employee having a $5,000 deductible. "If you discount that $5,000, then you've kind of gone outside all of the contracts and negotiations that have occurred," she says.

Instead of this discount, the department has taken other steps to make it easier for patients to manage their high deductibles. "We have some really nice payment plans that we allow people to go on. We do not charge interest," Braveman says.

She has talked to some of her peers who have begun to work with medical credit card companies. "We have not gone that route. I feel that then you become more of a bank. I'm not looking for that at this point," Braveman says. "We might have somebody paying $50 a month for three years. As long as they keep those payments coming in, I'm fine." ■

Don't let staff settle for misleading copay data

If some particularly dismal copay collection data came to your attention, chances are you'd want to scrutinize it carefully before presenting this to senior leaders.

At Cincinnati (OH) Children's Hospital Medical Center, the patient access and outpatient preregistration department is working with the hospital's Information Services (IS) department to automate its co-pay auditing processes, says **Michelle C. Gray**, MHA, director.

"Technology, in general, has helped us work smarter," says Gray. "We are constantly stretching our imagination and working collaboratively with our IS department to get the best results from our systems."

With the new co-pay auditing process, Gray expects to see increased copay collection rates and the ability to provide more accurate co-pay collection rates to senior level executives.

Although outpatient areas are considered to be centralized registration, there also are some decentralized registration areas, notes Gray.

"In the centralized areas, we have always audited copays," she says.

In 2010, one of the decentralized areas pre-

COMING IN FUTURE MONTHS

- Simple ways to get compliments from patients
- Stop EMTALA violations with ED collections
- Convince reluctant staff to make a career of access
- Give staff expertise to educate patients on coverage

sented its copay percentage during a presentation to senior leadership. "It wasn't very high, and so, our new CEO/president wasn't very happy with that. They knew we could do better," Gray recalls. "What came out of this meeting was an intense, hospitalwide focus on copay collection."

The presentation "kind of lit a fire under all of us," says Gray. "Before, it was an area that really wasn't discussed. It became a topic that was on everybody's top list to look at and do a better job at."

Concerns about data

Patient access leaders were skeptical about the accuracy of the department's copay data, because it seemed very low compared to what was being collected in centralized registration areas, Gray reports. Those areas audited copays daily, she says.

"Our numbers weren't close to theirs at all. We started to question, just how accurate is this data?" says Gray. "Our copay collection rate was being rolled into everyone else's."

Gray and her colleagues set out to work with the department that generated the original report to develop a more accurate copay report to distribute to senior level executives. An auditing tool was developed that every registration department could use, Gray says. "Once we start to generate the data, we can see which departments are low. We can put some strategies in place to help those departments raise their copay collection," she says.

The hospital's internal auditing department is in the process of contacting other hospitals to identify an acceptable copay collection rate, so that the hospital can compare itself with others, adds Gray. "We tried to take how we audit on paper and to automate it in the system," she says. "This new auditing process, even though it's not perfect, it's probably about as good as it's going to get."

Gray says that when the summary report is complete, the percentage might be the same or higher, "but at least we will know that it is pretty accurate."

SOURCE

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