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September 2011: Vol. 30, No. 9
Pages 97-108

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AHC Media

Insurer won't pay, says auth wasn't provided? Prove otherwise!

Your hospital can put a stop to costly penalties

If one of your registrars followed payer requirements to obtain a required authorization, it might become a "he said/she said" situation if the claim is later denied.

When fighting unfair claims denials, "technology can add to your success," says **Carol Plato Nicosia**, CHFP, CPAM, MBA, administrative director of corporate business services at Martin Memorial Health Systems in Stuart, FL.

"Most of our denials relate to authorization issues," says Nicosia. "Authorizations are the single most costly part of our revenue cycle: obtaining them, documenting them, and fighting with payers over them."

The patient access department at Advocate Condell Medical Center in Libertyville, IL, is seeing a "huge increase in authorization requirements," according to **Margie Mukite**, director of patient access. "They keep adding different procedures. It is getting overwhelming."

Payers and providers incur additional costs due to the authorization process, adds Nicosia. "The only cost savings is when an insurance company is able to deny the service because of the lack of an authorization," she says. "It sure seems like a lot of wasted effort on both sides."

The most complicated denials occur when the provider has asked for an authorization for a certain CPT code and the actual procedure ends up being something slightly different, says Nicosia. "Those will create a denial that always has to be appealed," she says. "This is a perfect example of

EXECUTIVE SUMMARY

Patient access departments are seeing increasing numbers of claims denied due to lack of authorization, even when the authorization was, in fact, obtained. By recording calls, registrars at Martin Memorial Health Systems were able to get payment for a $12,000 denied claim. To successfully appeal denials:

- Record all phone calls with payers.
- Be able to prove you left a message after hours.
- Specify whether the authorization is for outpatient or inpatient status.

wasted money on a process that is totally unnecessary, because the procedure was medically necessary in the first place."

To overturn these denials, Martin Memorial's registrars now record telephone calls regarding authorizations. "These calls, and actual faxes, are indexed to accounts and can be used to help in denial recovery," she says. Registrars take these steps:

- Phone numbers and the name of the person spoken to are documented.
- All phone calls with payers are recorded.
- Any documents received from the payer are scanned to the account for future reference.
- If the patient claims he or she does not have insurance, the patient signs a form stating that if insurance is discovered later, it will be the patient's responsibility to appeal the denied claim.

"The most proven method is recording calls," says Nicosia. "Some payers do not like it, so we make sure we put it in our contracts." Within one week of recording calls, registrars were able to prove to a payer that they had indeed performed a timely notification of admission, which meant a $12,000 denied claim was paid, reports Nicosia.

When a payer refuses to pay a valid claim, however, Nicosia says that it is ultimately the patient's responsibility to resolve the matter. "The hospital has provided services and needs to get paid. The business office is only a conduit," she says. "The ultimate responsibility lies with the patient in situations that are not straightforward."

Recordings are used

Whenever a registrar at University of Louisville (KY) Hospital speaks to anyone at an insurance company, use of a tracking device (Trace, from the White Stone Group, Knoxville, TN) is mandatory, says **Mary G. Lawson**, BSN, MPA, director of admissions.

"All of our registration areas use it, as well as care coordination, scheduling, the business office, and [Health Information Management]," says Lawson. "This records everything that is said when we are verifying that authorization for that hospitalization or procedure, or notifying the insurance company that a patient has been admitted."

State laws vary, requiring that either one or both parties must be aware of the recording, notes Lawson. "Trace notifies the party we are calling that they are being recorded," she adds.

Registrars document the number of the recording in the patient's chart, says Lawson, and if the claim is later denied, the recording is used by to the hospital's care coordination to appeal it. The same process is used if the notification of a patient's admission occurs after hours and is left on the recorded line of the payer, because the payer might later say they never received notification, says Lawson.

"It sometimes happens that they will say that the episode of care was never opened," she says. "Some insurance companies charge us penalties. It may be a certain amount of money, or they may deny the first day."

When a denial is sent to case managers, they can look at the notes in the patient's case and listen to the recording, says Lawson. "They write their appeal letter based on that information," she says. "We've had very good success with that." *(See stories on authori-*

Hospital Access Management™ (ISSN 1079-0365) is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

POSTMASTER: Send address changes to Hospital Access Management™, P.O. Box 105109, Atlanta, GA 30348.

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Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $399. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $80 each. (GST registration number R128870672.)

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zations now being required, below, and avoiding denials due to changes in the patient's status, below right.)

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Auths becoming more numerous and detailed

Payers going 'down to CPT code'

While payers used to encourage registrars to notify them that a patient was hospitalized, they are now requiring it, says **Mary G. Lawson,** BSN, MPA, director of admissions at University of Louisville (KY) Hospital,.

"Payers are also requiring authorization for high-dollar imaging procedures that they weren't before," she says. "They get very detailed, down to the CPT code." Here are changes that the department made to obtain authorizations:

1. The scheduling system was revamped.

In most cases, the patient arrives with an order, or an order is sent at the time of scheduling, so registrars know exactly which procedure the patient is going to have. "In an ideal world, the authorization would come with the order," says Lawson. "If not, we are setting up our scheduling system so that we know which payers require authorizations for which procedures."

The scheduling system now has specific payer fields if authorization is required for a procedure, she explains, such as CPT code 71250 for a CT of the chest, which will populate the authorization field on the schedule as "Need."

2. Clarification is obtained as to whether the authorization is for inpatient status.

"We have a list of 1,700 procedures that Medicare says are inpatient. Until recently, we had really been following that," says Lawson. "But as we move to more minimally invasive procedures, insurers are now saying that some of these cases need to be outpatient."

Increasingly, payers are denying some claims with inpatient codes, saying they should have been done on an outpatient basis, says Lawson. "Our case manager works very diligently to get those overturned. We enlist the help of the physician as necessary."

To prevent these kind of denials, Lawson says that registrars first verify if a procedure is a covered benefit, and if so, whether it is covered as an inpatient or outpatient.

3. Registrars begin the process five days before the patient's arrival.

"By the time we get to that point, we pretty much know that cancellations are going to be minimal," says Lawson. It also gives registrars enough time to make necessary corrections, such as informing the payer that a procedure is going to be inpatient, she adds.

In some cases, registrars need to contact the physician's office to prod them to initiate the authorization process, as some insurance companies require at least three days to give an authorization, says Lawson. "We may need to tell them, 'Either you start the authorization process today, or we may need to postpone surgery,'" she says.

4. Staff are careful to identify the patient's primary insurance.

While denials related to eligibility total less than 1% of all claims, according to Lawson, registrars still are striving to identify the patient's primary. "Patients may have multiple carriers, and we have to get the primary insurance correct. That can be a challenge," says Lawson. "The patient may pull out two insurance cards and they can't tell us which one is primary."

Registrars use several tools to complete insurance verification, including an embedded product in the Admission/Discharge/Transfer system, says Lawson. "Eligibility denials are usually human error, which occurs when the registrar does not accept what the system is indicating as primary," she says. "This mostly occurs in high volume areas, such as the emergency department." ■

Don't allow changes in status to bring denials

You must notify payer immediately

Previously, case managers at University of Louisville (KY) Hospital were assigned by service, and "they were all over the place," says

Mary G. Lawson, BSN, MPA, director of admissions.

"Even in the best hospital, when trying to cohort patients, there is always one or two patients that may get assigned to a different floor because of bed availability," she explains. To avoid confusion, says Lawson, the case managers are assigned by floor instead of by service. "They now have the pulse of every single patient," she says. "Communication has improved. They create a bond with the floor nurse, and interdisciplinary rounds are being instituted."

Case managers immediately know when a patient goes from observation to inpatient status, and they will obtain the necessary authorization from the payer, says Lawson. If the claim is later denied, the appeal should be successful so long as there is adequate documentation, she adds. "We put a strict policy in place, and we have educated staff on this, on what to do when a patient is converted from outpatient to inpatient status," says Lawson. "We monitor the bed control system, and once that patient is converted, insurance is notified immediately."

These steps occur:

1. Bed management receives an order to change a patient from observation to an inpatient from the patient unit or physician.
2. Once the order is completed, the insurance company is notified of the admission.
3. Case management is notified of the authorization needed.

At times, case managers have to justify why an insurance company wasn't notified about a patient's admission, says Lawson. "It may be that a patient was in a motor vehicle collision and their wallet was left in the car, or the patient may be unconscious," she says. "In that case, it wouldn't be until the family comes that we are able to determine that they had insurance." ■

Financial counseling saves $1.3 million

No increased staffing needed

In 2010, Sutter Health Sacramento (CA) Sierra Region, which consists of eight acute care hospitals, saw a 30% increase in its uninsured population.

"We had not anticipated the national financial downturn or the subsequent influx in our uninsured population," says **Michael Taylor**, regional director of patient services and patient access/financial services. "Thankfully, our structure was in place to handle the volume and assist these patients."

Two years ago, patient access leaders redesigned the financial counseling model to place more emphasis on uninsured patients, due to a minor increase that had been identified, he explains. "We were also aware that one of the deliverables of healthcare reform was to make new programs available for uninsured patients," adds Taylor. "An increased need for assistance was expected."

There was also a Medicare affordability initiative throughout the organization, focused on reducing the operational cost of providing healthcare services to the communities served, adds Taylor.

One of the opportunities identified to reduce costs and improve patient assistance was vendor costs of $1.4 million annually, which was being spent to assist patients with eligibility for government programs including Medi-Cal, California's Medicaid program, he says. "We also felt that our present model for assisting the uninsured and underinsured was very confusing for our patients," says Taylor.

Previously, patients would meet with a financial counselor to validate their uninsured status, be introduced to a representative from the eligibility assistance vendor, and receive post-service collection calls and separate customer service assistance if the patient had questions regarding their account. "The process was redundant and provided suboptimal support for this patient population," says Taylor.

Processes centralized

A patient financial advocacy workgroup was created, with hospital employees placed at each of the eight facilities, as part of a comprehensive redesign of the patient access and patient accounting departments.

The advocates help uninsured patients enroll in government programs, identify other payer sources such as COBRA, give service cost estimates, and offer charity assistance. "We were able to accomplish this *without* increased staffing, by centralizing the insurance verification, notification, and authorization processes. This

EXECUTIVE SUMMARY

After Sutter Health Sacramento's Sierra Region's eight hospitals redesigned its financial counseling model to help uninsured patients obtain coverage, the vendor cost for eligibility assistance decreased from $1.4 million to $100,000, and private pay cash collection increased by $500,000 per month. They took these steps:

- Eliminated redundant processes.
- Combined financial counseling and private pay collection.
- Gave patients a single employee to communicate with.

was traditionally part of the financial counselor workload," says Taylor. "We also assigned private-pay collection resources to the front end."

The objective was to evaluate all functions performed in all areas to avoid redundancy, improve quality, and reduce cost, says Taylor.

Traditional patient access functions including insurance verification, authorization, notification, pre-registration and, in one service line, scheduling, were centralized in the business office along with billing and account follow-up. "Financial counseling and private pay collection were combined," says Taylor.

Training provided

The workgroup employees were trained in screening for all potential payers, charity, and bad debt management, says Taylor. "The employees chosen all had some exposure to facets of private pay patient assistance, but a more comprehensive knowledge was required," he explain. These steps were taken:

Training was provided by the hospital's government program conversion specialist, who had extensive experience in government screening and eligibility. The hospital's bad debt and charity coordinator trained staff on private pay collection and charity determination processes.

"We still retained an outside vendor to assist with disengaged patients, or patients that required home visits to assist with application processes," says Taylor.

The vendor cost for eligibility assistance decreased from $1.4 million before the transition to $100,000 in 2010.

The workgroup was made responsible for all uninsured and underinsured patients, which are defined as insured patients with a patient liability of $5,000 or greater after insurance payment.

"Assistance provided includes government program eligibility assistance, or other payer assistance such as COBRA or third-party liability, service cost estimates, charity eligibility, and payment plan assistance," says Taylor.

One to three advocates are located at each facility, based on patient volume.

Three advocates work in the central business office to assist scheduled patients during the pre-registration process, adds Taylor.

The workgroup is measured on private pay accounts receivable days, accounts converted to government programs or alternative payer sources, accuracy of estimates, private pay cash collection, charity determination, and reduction of fees paid for vendor assistance.

Private pay cash collection, which averaged $1.4 million in 2009, increased to an average of $1.9 million a month in 2011, and the number of inpatient accounts converted to government or insurance payer increased from 2,052 in 2009 to 2,533 in 2010, reports Taylor.

The advocates are responsible for managing the account through collection, government or other payer conversion, payment, or adjudication.

"The patient has *one* employee to communicate with, from point of service through the aging of their account," Taylor says.

SOURCE

For more information on improving financial counseling processes, contact:

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Not just a good, but great first impression

If registration goes smoothly, that great experience is going to carry through the rest of the patient's stay, according to **Betty Bopst**, director of patient access at Mercy Medical Center in Baltimore, MD.

"We are the ones they see first. We want to build loyalty. If we do that, the patient is for-

giving of our mistakes because they are loyal to us," Bopst says. "But if things don't go well, you can ruin it on the front end."

At St. Rose Dominican Hospitals in Henderson, NV, if a procedure must be delayed for the patient's safety or other unavoidable delays occur in registration areas, registrars explain the reasons for this, says **Natasha R. Meinecke**, interim patient advocate. "Our patients have shared that they appreciate our honest communication," she says. "If a patient is waiting for a procedure or hospital bed, we make every effort to meet his or her expectations while he or she waits."

Patients and loved ones might be fearful, in pain, or frustrated as a result of their healthcare needs, says Meinecke. "It is important that registrars are sensitive to those needs, expressed and unexpressed, by truly connecting with our patients," she says.

Registrars offer comfort items such as extra pillows and blankets, as well as eye masks and ear plugs to help reduce sound and light, says Meinecke. "All of these items promote a more healing, restful environment," she says.

Patients might quickly become frustrated at registration, such as when he or she doesn't realize you need to quickly verify their identity so that you can locate a prior medical record number, says Bopst. "To this day, the objectives of registration are still very misunderstood," she says. "It's not all financial. The bigger piece is for us to identify that person without a shadow of a doubt."

Patients might insist they have no existing records as they haven't been to the hospital before, but a medical record would have been created for them if there was previous labwork or an outside film was sent in for interpretation, says Bopst. "If a patient tells us, 'I've never been here before,' we don't just take that at face value," she says. "We continue to do our search to see what we can find."

Registrars at Mercy Medical Center take these steps to make a great first impression:

• If patients have to wait for a longer time, registrars go down to the emergency department to obtain warmed blankets to make them more comfortable.

"That is something that patients really appreciate," says Bopst.

• If it's around meal time, registrars contact the patient's doctor to see what they can have to eat, and they will get a meal for the patient and whoever is accompanying them.

• If a patient leaves on a bad note, staff members check in with them later.

"With certain patients, you have to give up on getting the information and wait until they get to their room later in the day," says Bopst. "If a piece of information is missing, we can then try again and see if we can pick up a little something else."

Even if no information is needed, Bopst says her registrars have found that patients like being checked on to see how they are feeling.

• If a patient seems to be waiting too long for transportation, a registrar transports them.

"We'll put them in a wheelchair and take them up right to the room," says Bopst.

• Relationships are formed with "regulars."

Patients like to feel as if you have more of an interest in them than just getting their social security number, says Bopst. "We have a lot of frequent fliers here," she says. "People like to be recognized, and they like to be known." *(See related stories, below, on evaluating customer service skills, and having applicants meet with registrars, 103.)*

EXECUTIVE SUMMARY

If registration goes smoothly, this great first impression is likely to remain throughout the patient's stay. Do the following for patients:

- Offer warmed blankets or meals.
- Have registrars check on patients later in their stay.
- Transport patients directly to their rooms.

SOURCE

For more information on improving patient satisfaction in registration areas, contact:

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Evaluate service skills of next access applicant

Listen for signs of trouble

After **Betty Bopst**, director of patient access at Mercy Medical Center in Baltimore, MD, finishes telling a patient access applicant the extent of the commitment that comes with the

job, he or she sometimes tells her flat out, "This job is not for me."

"I respect them a lot for saying that," Bopst says. "They begin to understand the depth of what's required in this role. Then they consider their own skill set and recognize that it's not right for them."

The most important qualities in a registrar are the ones that can't be trained, such as the ability to make a worried patient feel comfortable and welcomed, according to Bopst. "You want someone who just really loves to deal with the public, even under trying or chaotic circumstances," she says.

When Bopst meets a prospective registrar, "I know that they either have it, or they don't." She looks for individuals who can make a patient feel as if they are genuinely interested in helping them through the process, instead of just another registration that has to be completed. "After you hire someone, you don't want to later say, 'Hey, what happened? You're not the person I interviewed,'" says Bopst. "I have been dead wrong before, but not often in all these years."

Bopst evaluates customer service of applicants with these methods:

• She listens closely and observes the person's body language.

Anyone might be a bit nervous during a job interview, but Bopst says she likes to see that applicants appear fairly comfortable with her during the interview.

• She isn't guided only by the applicant's resume.

"Someone may look great on paper but may not be cut out for this job," says Bopst.

While she values experience, Bopst says "the biggest thing is the personality." She says she would rather have a recent high school graduate with a great attitude than a registrar with many years of experience and a poor attitude.

• She gives a scenario and asks the applicant what he or she would do.

"I believe that when I ask them this, what they tell me is really close to the same way they would handle it with an actual patient," Bopst says.

She often asks applicants what they'd do if they were trying their hardest to help the patient, and he or she still refused to give information because they'd already given it to others multiple times. "I listen for their voice raising in any kind of anger," says Bopst. "In our role, we have to be assertive at times, but never aggressive. When someone is very upset, you still need to help them."

Bopst says that a good response to this scenario would be, "I really need this information so that we can locate your records and ensure we have everything correct so we can move on to your treatment area."

On the other hand, if the applicant reacts defensively, by giving a long list of excuses or their own complaints, this is a red flag for Bopst. "I always tell staff, 'Nobody cares about your rules.' They don't need to know that you are short staffed or if you've worked a double shift," she says. "You keep all of that completely to yourself." ■

EXECUTIVE SUMMARY

When interviewing applicants, emphasize the commitment that is required and the ability to make people feel comfortable. To assess customer service skills:

- Ask what they would say if a patient refused to provide information.
- Consider recent high school graduates with the right attitude.
- Offer the opportunity to ask questions of registrars.

Ask applicant to meet with other registrars

Discover the 'real personality'

Have you ever suspected that an applicant is just telling you what you want to hear in order to get hired? If **Betty Bopst**, director of patient access at Mercy Medical Center in Baltimore, MD, has any doubts about someone she's interviewing, she relies on what her staff has to say.

After the interview is completed, Bopst invites the applicant to go meet some of the staff and ask whatever questions he or she would like. "If they're trying really hard with me and putting on a front, they may let down their guard a little bit with the staff," she says. "This allows me to see the real personality."

Occasionally, Bopst finds that her suspicions were correct about the applicant putting on a false front. "Sometimes what takes place is very surprising and gives you another perspective,"

she says. "They are more themselves with the staff. They will ask them different questions than they would ask me."

During interviews, Bopst emphasizes the fact that registrars are considered "essential" staff, which means that they must stay if a snowstorm occurs and replacements can't get to work, and they must work rotating weekends and holidays. "They may agree and nod their head enthusiastically, but when they get with the staff, it comes up in conversations that they really don't like the idea of working Saturdays," she says. "I listen for things like that." ■

Account `uncollectable?' Try a different approach

Be more patient-friendly

"If you don't pay this bill, we're going to send you to a collection agency." This was a commonly heard statement by patients at Tallahassee (FL) Memorial HealthCare, when **Joan S. Braveman**, director of patient access and financial services, took over the business office.

There was a markedly different approach to collections then. "I felt that our customer service people were really trained to be collectors. What they were really doing was hounding patients for payments," says Braveman.

The attitude of "you owe us that money, and we're going to call you until we get it," has become much less threatening and more patient-focused, says Braveman. Staff now make statements such as "I'm calling to let you know that we have sent you three bills, and it is our practice to sent the account to a collection agency. Before we do that, I want to give you an opportunity to help you pay this bill," says Braveman.

"The response to that is great. People want to do something at that point," says Braveman. "We have become advocates for the patient: We're the good guys, and we don't want to ruin your credit score."

The approach has paid off financially as well, says Braveman. She points to a woman with a $27,000 bill, who has made monthly payments for years totaling over $14,000 to date. "I think part of the reason is that we treated her with respect and didn't threaten her," says Braveman.

Presumptive charity

In some cases, Tallahassee Memorial's registrars have told a patient, "We are looking at your account. We're quite certain you will qualify for charity care. All we need is a copy of your tax return," and received a disappointing response.

"People may tell you, 'Nobody can hurt my credit any more than it already is,'" says Braveman. For this reason, the department is looking at taking the approach of "presumptive charity," she reports.

"There are some very strict Florida statutes that make it clear that for us, as a not-for-profit hospital, we need to have documentation to claim something as charity on our cost reporting," says Braveman. "We do get audited on that. They will randomly pick a certain number of accounts, and we provide the documentation for those."

These audits means tax returns, unemployment statements, housing statements, a picture ID, bank account statements, and credit reports need to be on file, she says. "On the other hand, [the Centers for Medicare & Medicaid Services] at the federal level has said that as long as you are consistent across the board, you can presume charity," says Braveman.

This presumption means that even if the patient is not being compliant in meeting state regulations, the hospital could presume charity based on parameters such as a credit score under 450 or a bankruptcy in the last five years, she explains. "Were we to do that, we couldn't claim it on our state reporting, but we could on our federal tax reporting," says Braveman. A lot of these accounts potentially could be classified as free charity care, she explains.

"We are looking at that, because what happens is those accounts go to the collection agencies," says Braveman. "And I typically get

EXECUTIVE SUMMARY

Contact patients right before an account is sent to collection to give them the chance to avoid a negative impact on credit scores. To improve chances of collection:

- Tell patients if they are likely to qualify for charity care.
- Offer an uninsured discount right away.
- Use software to determine if patient is likely to pay.

calls from them, saying, 'You're not sending me something I could ever collect on. There is no money there.'"

Braveman says that previously, when bad debt was sent to a collection agency, "it was pretty collectible. You made a couple of phone calls, and the patient paid it. That's not happening today." While collection agencies typically collected around 12% or 13% of the hospital's bad debt, today they are only collecting about 2%, she reports.

Part of the reason is that members of the patient access staff are doing a better job of getting the money upfront. "We are having conversations with patients. By the time the accounts are going to the agency, they are pretty well-worked," says Braveman. "A bigger part of it is that people just don't have the money."

Over three months, staff send three bills and make one phone call, for a total of four contacts with the patient, says Braveman, and a precollection agency gets involved if there is no response.

"They are a collection agency, but they do not report to the credit reporting agencies," says Braveman. "If there is no response, then it does go to a true collection agency, and it shows up on the patient's credit report." *(See related story, below, on which patients are likely to pay.)*

SOURCE

For more information on improving collections, contact:
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Which patients will pay, which are time-wasters?

One question that members of Tallahassee (FL) Memorial's patient access department have struggled with is whether it makes sense to keep going after a person who simply has no resources, says **Joan S. Braveman**, director of patient access and financial services. The department installed software in August 2010 that gives customer service representatives the ability to look at how likely a patient is to pay.

"If they get a red light, that's basically saying, 'Do not even waste a moment. Just let it go through the process," says Braveman. "We are able to eliminate wasting time on people who are never going to pay."

If an uninsured patient gets a green code, however, staff members call them immediately to offer them the uninsured discount right away over the phone, says Braveman. "We can take checks and credit cards over the phone. They are going to pay, and it's just a matter of how quickly," she says. "The yellow-coded ones are where we are spending our energy, because those could go either way."

Braveman says initially, she was concerned about allowing a collectible account to slip through the cracks based on the system's information. "But for the one person in there who really would have paid when you called, we're still going to get paid," says Braveman. "As soon as they get a letter from a collection agency, they'll be on the phone to pay their bill."

Overall, registrars convey the message "We really are here to help you" over the phone lines, says Braveman. "I think the way we're doing it will help tremendously. We are getting the buy-in from patients."

Still, says Braveman, "We don't want the word on the street to be "Go to TMH and they won't ask you for money." "The message needs to be, 'TMH will work with you.'" ■

Ask for balance due on previous accounts

Present it in a positive way

Registrars at Fairview Northland Health Services in Princeton, MN, started collecting prior balances about a year ago, says **Steph Collins**, manager of patient access.

"Point-of-service collections is still a major focus," she adds. "But we have learned that the front desk needed to take a more active role in our prior balance collections."

The department has found that if patients are aware of the balance at the point of check in, they will be more open to paying because they know they will be asked for this every time, Collins says. "It is no longer just receiving a statement in the mail that is easy to forget or ignore," she says. "This requires the patient to respond in some way."

The department recently invested in software

EXECUTIVE SUMMARY

Asking for payment of outstanding balances at the time of check-in can increase revenue significantly, but patients often are unprepared or unaware. Use these strategies:

- Have financial counselors available to meet with patients.
- Offer the option of payment plans.
- Tell the patient their account is close to going to collection.

that allows front end staff to look up prior balances. 'We have started screening the next day's schedule for outpatient services, and speaking to patients about their prior balances," says Collins. "We find it very effective."

Collins estimates that more than 50%, and possibly as much as 75%, of patients have a prior balance. "Patients are informed about their out-of-pocket expenses that they either didn't know they had or had forgotten about," she says.

Offer options to patient

Fairview Northland's registrars collect prior balances using a "key words and key times" approach, which is a more flexible approach than scripting, says Collins.

"We have different key words to use at various times," she explains.

For example, if a registrar is asking for a prior balance, he or she might say, "We would like to make sure you are aware of your balances from previous visits with us. We want to verify that you are receiving statements and provide you with options, as well as answer any questions you may have. Would you be able to make a payment toward this balance today?"

"If we can present the information to the patient in a positive and professional way, we feel the patient will be more likely to make a payment on their balance," says Collins.

Registrars inform the patient that their account is close to going to collection and give the patient a chance to avoid this, she says.

Since starting to focus on prior balances, revenue collected from the front end has increased substantially in the past year, reports Collins. "We are continually tracking this revenue," she says. "We recently set up individual goals for staff that will help keep them on target."

Every registrar has a goal to collect a specific amount during each shift based on patient volume and the opportunity to collect prior balances and point-of-service payments. "The goals could change based on patient volume, shift change, or other workflow changes," says Collins. "These are tracked daily and weekly, and shared with all staff in the department."

If Collins notices many staff exceeding their daily goals, then she considers increasing the goals to encourage even more improvement. Goals also might change because a new tool is being implemented to help registrars provide more estimates upfront in various services, reports Collins.

"This will provide more opportunity to financially secure the account," says Collins. "We expect the goals to increase at that point." *(See related stories on giving options for payment, below, and giving staff access to accurate information, p. 107.)*

SOURCES

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- **Steph Collins**, Manager of Patient Access, Fairview Northland Health Services, Princeton, MN. Phone: (763) 389-6263. Fax: (763) 389-6446. E-mail: scollin1@fairview.org. ■

Give patients options for their prior balances

Some problems are easy to fix

When attempting to collect prior balances, registrars at Fairview Northland Health Services in Princeton, MN, often come across patients who are unprepared to pay the amount or don't realize they have a balance.

"We have found that if patients are not aware of prior balances, then the likelihood of collecting on them decreases," says **Steph Collins**, manager of patient access.

For this reason, patients are given the opportunity to meet with financial counselors who offer options, including payment plans, to take care of prior balances. "Our long-term goal is to include registration staff in making payment plans," adds Collins. "The main challenge is training and having the registrar feel comfort-

able doing this."

Offering payment plans can be tricky, especially if software goes down or an amount has to be negotiated, says Collins. "We have a guide to help us determine the acceptable amount of time allowed to pay off a balance and the required monthly amount," says Collins. "When patients cannot meet that, then staff have to feel comfortable enough to negotiate."

Process for rebills

If a past due balance is large, and the patient is found eligible for Medicaid, the balance might be covered if the visit was within the retroactive coverage time period, adds Collins.

"We also have a charity care program. This could possibly help patients where the Medicaid coverage did not cover the past due balance," she says.

The department also has had success with rebills due to the patient's failure to return requested information to the payer, therefore making the patient liable for the entire balance, says Collins.

Patients often weren't aware of the requested information, often involving accident or coordination of benefits information, or didn't understand the implication of them not returning it, says Collins. "This is an easy thing to fix and, therefore, get paid," Collins says. "We are able to connect the patient with the insurance -- sometimes right in our office -- and get the claim reprocessed by their insurance and paid. These are win-win situations for all." ■

Don't ask staff to collect without accurate info

Give them much-needed confidence

If a registrar tells a patient that he or she owes $500, he or she might be faced with the question, "Well, where did you get the amount of $500 from?"

"If they don't know how to answer that question, it can cause a lot of folks not to be comfortable asking the question in the first place," says **James Carey**, CHAA, patient access manager at University of Utah Health Care in Salt Lake City.

The department recently invested in creating a Microsoft Access system software tool, developed with the help of Chicago-based Huron Consulting Group, to give staff the ability to give accurate estimates for a patient's out-of-pocket responsibility.

"It uses the CPT procedure codes the patient is going to have for outpatient procedures and the ICD-9 diagnosis codes for inpatient," says Carey. "It also takes into account the insurance contractual amount, and the patient's coinsurance and maximum out-of-pocket."

This tool was a "huge help" for registrars, who are much more confident telling patients what they will owe, says Carey. "At our surgery check-in, especially in orthopedics, we always ask for any small amount a patient owes," says Carey. "Staff are trained in how to answer questions about the estimate we provide up front."

After a major push to improve upfront cash collections, registrars now have the ability to ask for payment on outstanding balances, reports Carey. Previously, if a patient owed a balance of $500 from multiple previous visits, for example, staff wouldn't have asked for payment. "Now, we will ask them for that outstanding balance at check-in for their upcoming procedures," says Carey. "We ask them what they can pay on their current outstanding balance today."

Walking a fine line

When point-of-service collections initially was being rolled out, Carey took great pains to convey to staff that the idea wasn't to upset patients.

"There is a fine line between trying to collect and harassing someone," he says. "Some patients may have just found out they will owe $2,000 for the procedure they are having."

Registrars still are instructed to bill patients if requested, but at least inform the patients about their liability. "Our biggest issue was always that they didn't understand the reasoning for the cal-

COMING IN FUTURE MONTHS

- Stop costly communication breakdowns with clinical areas
- Avoid claims denials for high-dollar imaging procedures
- Obtain retroactive disability coverage for patients
- Give access staff the ability to negotiate payment plans

culation of the estimate they were asking for," says Carey. "Previously, we had instances where the registrar would actually ask for a deposit that totaled more than the procedure itself."

These instances occurred because staff lacked access to accurate information about the patient's liability, but this situation is no longer the case, says Carey. Without the estimation tool, he explains, staff might have asked for the patient's entire $2,000 deductible without realizing that the procedure cost was only half that amount, for example.

Now, staff plug in the patient's benefits and the CPT code for the procedure, and the tool automatically deducts the insurance company's contractual amount. "This tool is taking into account that even though the procedure is $1,000, the insurance company's contractual amount is 50% of that," says Carey. "So we are really working off $500."

The tool works the same way for self-pay patients, who receive an automatic 30% discount. "There is an option the staff click for self-pay, which plugs in the 30% discount," says Carey.

All of four of the department's registrars are now comfortable asking for payments on estimates upfront, because they know the amount they are asking for is more accurate, he reports.

Registrars encourage patients to contact the payer directly if there is any confusion about their coverage. "We are seeing much higher deductibles and coinsurances. It can be a bit of a shock to patients," says Carey. "One of the messages that we tell our check-in folks is that it's really between the patient and their insurance company." For example, a registrar might say, 'This is the information we were given on this date by your insurance company, but feel free to verify your benefits with them. Here is the number to call."

At times, a patient informs the registrar that he or she met more of the deductible than was apparent when the registrar verified the benefits. "Insurance companies may take a long time to process a claim," says Carey. "A patient may have had a procedure the previous month, and in actual fact met their deductible, but the insurance company has not yet processed it."

In this case, the registrar simply takes the patient's word for it. "We never want to get into a situation where there is any kind of back-and-forth with a patient on how much they owe," says Carey. ■

Hospital Access Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles **completely.** Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- O A. access manager
- O B. director, access management
- O C. manager, patient accounts
- O D. supervisor
- O E. patient accounts representative
- O F. other _____

2. What is your highest degree?

- O A. ADN
- O B. diploma (3-year)
- O C. BSN
- O D. MSA
- O E. other _____

3. What is your sex?

- O A. male
- O B. female

4. What is your age?

- O A. 20-25
- O B. 26-30
- O C. 31-35
- O D. 36-40
- O E. 41-45
- O F. 46-50
- O G. 51-55
- O H. 56-60
- O I. 61-65
- O J. 66+

5. What is your annual gross income from your primary health care position?

- O A. Less than $30,000
- O B. $30,000 to $39,999
- O C. $40,000 to $49,999
- O D. $50,000 to $59,999
- O E. $60,000 to $69,999
- O F. $70,000 to $79,999
- O G. $80,000 to $89,999
- O H. $90,000 to $99,999
- O I. $100,000 to $129,999
- O J. $130,000 or more

6. Where is your facility located?

- O A. urban area
- O B. suburban area
- O C. medium-sized city
- O D. rural area

7. In the last year, how has your salary changed?

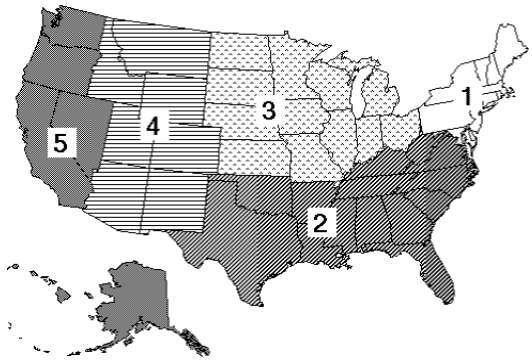
- O A. salary decreased
- O B. no change
- O C. 1% to 3% increase
- O D. 4% to 6% increase
- O E. 7% to 10% increase
- O F. 11% to 15% increase
- O G. 16% to 20% increase
- O H. 21% increase or more

8. What is the work environment of your employer?

- O A. academic
- O B. agency
- O C. health department
- O D. clinic
- O E. college health service
- O F. consulting
- O G. hospital
- O H. private practice

9. Please indicate where your employer is located.

- O A. region 1
- O B. region 2
- O C. region 3
- O D. region 4
- O E. region 5
- O F. Canada
- O G. other



10. Which best describes the ownership or control of your employer?

- O A. college or university
- O B. federal government
- O C. state, county, or city government
- O D. nonprofit
- O E. for profit

11. How long have you worked in your present field?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

12. How long have you worked in health care?

- O A. less than 1 year
- O B. 1-3 years
- O C. 4-6 years
- O D. 7-9 years
- O E. 10-12 years
- O F. 13-15 years
- O G. 16-18 years
- O H. 19-21 years
- O I. 22-24 years
- O J. 25+ years

13. Which certification best represents your position?

- O A. FMFMA
- O B. CHAM
- O C. RRA
- O D. MSA
- O E. other_____

14. How many hours a week do you work?

- O A. less than 20
- O B. 20-30
- O C. 31-40
- O D. 41-45
- O E. 46-50
- O F. 51-55
- O G. 56-60
- O H. 61-65
- O I. 65+

15. If you work in a hospital, what is its size?

- O A. <100 beds
- O B. 100 to 200 beds
- O C. 201 to 300 beds
- O D. 301 to 400 beds
- O E. 401 to 500 beds
- O F. 501 to 600 beds
- O G. 601 to 800 beds
- O H. 801 to 1,000 beds
- O I. >1,000 beds
- O J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2011

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, AHC Media, P.O. Box 105109, Atlanta, GA 30348.