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AHC Media

Patients are price shopping: They'll want more than just `guesstimates'

Expect more calls from 'bargain hunters'

A patient wasn't happy with the answer she received after asking registrars at Botsford Hospital in Farmington Hills, MI, the cost of a high-dollar procedure, and she insisted that she could get it performed for half of the price quoted.

"One of the hospital social workers contacted the other facility, with the patient present. They discovered the other facility had misquoted their pricing," says **Paula Andres**, CHAA, manager of patient services in the pre-arrival department. "A little research went a long way."

If a patient isn't satisfied with your response on what a procedure will cost, the hospital potentially could lose tens of thousands of dollars in revenue, adds Andres. "The main problem for patient access stems from those who call around and won't give a name," she says. "It is a growing problem, but also an opportunity."

To encourage patients to choose Botsford Hospital when they call for a price quote, Andres does the following:

• She asks for the patient's name and the physician's name, and she engages them in conversation.

"This gives them more of a feeling of commitment and possibly wins them over," Andres says.

• She tells the patient what discounts are available if the amount is paid prior to service, and she explains available payment plans.

"Asking additional questions and developing appropriate scripting helps,"

EXECUTIVE SUMMARY

Members of the patient access staff are fielding numerous calls from patients inquiring about costs of services. To avoid incorrect estimates and improve satisfaction:

- Inform patients about discounts and payment plans.
- Use accurate coding.
- Obtain detailed information from the patient.

says Andres.

• She performs research by being a "secret shopper" to determine what charges are being given out by competitors.

"This can give you a better of idea of how to deal with the callers, or to approach hospital executives as to where you stand in comparison to competitors," says Andres.

Many more calls

Previously, registrars at Marlton, NJ-based Virtua received about one phone call a month from a patient asking how much a service would cost, but they now field five or 10 such calls each day, reports **Thomas P. Buckley**, assistant vice president of patient business services.

"Prospective patients usually call for the purpose of price shopping," he says. "Similar to receiving estimates from a contractor or any service provider, patients are looking for the best price."'

Patients at Mercy Medical Center in Baltimore, MD, are much more cost-conscious when selecting medical services, according to **Sheila Holzman**, RN, CHAM, manager of the scheduling office. This change is due, in part, to employers switching to health reimbursement arrangements and health savings accounts with high deductibles. Andres says today's patients are "avid shoppers and bargain hunters. They are looking for the most reasonable provider for their needs."

Give accurate quotes

Members of Andres' staff rely on CPT codes obtained from the provider's office to give estimated prices for surgeries.

"Our finance department uses a tool based on historical data," she says. "Ideally, it would pool data using the specific provider information."

Botsford Hospital's registrars offer discounts for patients who pay over the telephone with a credit card or echeck prior to the date of service. "This gives the patient ease of mind that it's pretty much a done deal financially, and they have met their obligation," says Andres. She says to take these steps to give accurate estimates:

• Ensure the estimate is based on accurate coding from the physician's office.

"This is crucial," says Andres. "These codes can be used in conjunction with past billing history to calculate the average cost of a procedure or exam, if technology is not available."

• Don't omit multiple codes that should be included with tests and procedures.

"There is nothing worse than giving a price quote of a couple of hundred dollars for one code and having the patient receive a bill for over $1,000 because not all the codes included were calculated for the estimate," says Andres.

• Be certain you understand the rules of each clinical area.

If the radiology department typically includes additional views for certain findings beyond the original exam, for example, Andres includes this extra charge in estimates.

• Don't use "cheat sheets" for price quotations.

If you are calculating a price quote manually to obtain an average cost based on historical costs, remember that costs might rise over time. "Prices may change

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without all hospital departments being made aware," says Andres.

Monies collected upfront result in fewer dollars being spent at the back end due to multiple statements going out, bad debt collection, and labor costs, says Andres, adding that point-of-service collections increased from $275,000 in 2010 to $500,500 in 2011 due in part to more accurate estimates.

"Industry statistics have proven that the sooner the money comes in, the more ensured you are of collecting it," she says. *(See related stories on information needed to give accurate estimates, below, how to direct questions about prices to a single area, right, and steps to take if an inaccurate estimate is given, p. 40.)*

SOURCES

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Stop sticker shock: Get info in advance

Give patients fewer financial surprises

Patients who ask about the price of a surgery or diagnostic test probably won't realize that you need many more pieces of information to give them a correct answer.

"Most organizations experience a higher level of patient satisfaction when patients are informed of their obligations prior to receiving service," says **Patrick Stone**, patient access services applications administrator at Texas Health Resources in Arlington. "This avoids 'sticker shock' 30, 60, or 90 days after treatment, when the insurance company finally processes the claim."

To provide an accurate estimate, however, Stone says you must know this information:

- **The specific procedure(s) that the patient is scheduled to receive.**
- **The allowable insurance for the service(s) the patient is requesting a price quote on.**

"Most healthcare providers contract with insurance companies, and therefore charges are typically irrelevant," says Stone. "Services may be paid on a fee schedule, DRG, per diem, or some other reimbursement methodology."

- **The patient's specific benefits.**

Many employers are shifting costs to the patient with larger deductibles, co-insurance, and co-pays, says Stone, and benefits change throughout the year as the patient incurs services.

"Getting accurate benefits can be a challenge, due to the timing of claims processing," he adds.

Technology is key

To give more accurate estimates to patients, technology is key, says **Paula Andres**, CHAA, manager of patient services in the pre-arrival department at Botsford Hospital in Farmington Hills, MI.

Registrars use price estimation software that combines and processes payer plan codes, billing history, procedure codes, and the physician performing a procedure to calculate a patient's out-of-pocket expense.

"This estimate not only addresses copays, but unmet deductibles and coinsurance as well," says Andres. "Our patients seem to appreciate the fact that there are no surprises when their bill comes."

Registrars enter demographic information, procedure and diagnosis codes, the patient's payer, plan and group numbers, and the physician performing the procedure. The system calculates out-of-pocket expenses based on the plan code, historical charges, and the payer contract. "It then gives us a readout of what has already been met by the patient, and what the patient will owe for this particular visit," Andres says.

Because scheduled patients are registered three weeks in advance, adds Andres, it gives them time to pool their resources if monies are due in order to take advantage of the prompt-pay discount option.

"Staff like it, since it can lead to incentives for them when pre-set goals are met," says Andres. "It becomes a bit of a friendly competition, which motivates them in their work." ■

Send price quote calls to a single place

Registrars in multiple areas of Botsford Hospital in Farmington Hills, MI, were fielding increasing numbers of calls from patients asking for information on the

cost of various services.

"This led us to assign one area for all inquiries, to ensure consistency," says **Paula Andres**, CHAA, manager of patient services in the pre-arrival department, which was chosen as the hospital's "price estimation center."

Vidette W. Owens, MHA, manager of financial counseling at the University of Mississippi Medical Center in Clinton, says, "Providing price estimations should be limited to an individual, or a team of individuals, whose primary responsibility is patient financial assistance."

The price estimation process is assigned to the hospital's financial counseling unit, and the reimbursement analyst team assists with contractual agreements and historical claim data, says Owens.

Marlton, NJ-based Virtua recently centralized the process for price estimates at its four hospitals, by directing all phone calls to the patient accounting department, reports **Thomas P. Buckley**, assistant vice president of patient business services. Staff members in all areas with patient contact are instructed to refer patients to this number.

"The goal is to funnel the questions to where they can best be answered," says Buckley. Patient business staff members are trained to obtain as much information as possible to answer the question, "What will this procedure cost?"

"Most patients don't know what a CPT-4 code is or an ICD-9 diagnosis," says Buckley. However, if the patient describes why they are coming to the hospital, such as for a hernia procedure, staff can then use data from the hospital's health information management coding system to calculate the cost.

Next, staff members obtain the patient's insurance coverage details and the deductible, coinsurance, or copay. "If the patient is self-pay, we identify the average charges for the visit, and the discount off of charges that the organization can offer," says Buckley. "If the patient has insurance, we identify how the insurance company will pay this claim."

Staff members use payer websites and insurance company contract information to answer these questions, he adds.

"Using all available information will provide an accurate dollar figure for the patient responsibility," says Buckley. "This helps to keep the patient informed and satisfied going forward." ■

What if estimate is wrong? Say this

Any patient who ends up owing $1,200 for a procedure after being given an estimate of $300 is likely to be very unhappy, even if the registrar carefully explained the original quote was just an estimate.

Estimates will be incorrect if additional or different procedures are done that weren't included in the original estimate, says **Paula Andres**, CHAA, manager of patient services in the pre-arrival department at Botsford Hospital in Farmington Hills, MI.

Once a quote is given, some patients believe that no matter what else happens in the course of treatment, they should only have to pay the amount that originally was quoted, she adds.

"Occasional errors in estimates do occur," says Andres. "Patients may understand it was an error. But like shopping in a store, some feel that the advertised price should be honored."

Emphasize the word "estimate"

If staff use appropriate scripting up front, you can fall back on this when the patient calls to complain, says Andres.

"The emphasis is on the word estimate," she says. "Walk through the charges with the patient, to see why the estimate was higher."

Because the physician, radiologist, or surgeon might perform additional procedures or tests, registrars need to emphasize that the estimate is based strictly on the information given by the physician at the time of the order, she says.

If a patient is upset because an estimate was lower than the actual cost of a surgery or procedure, staff could explain this by saying, "The surgery became more involved and took longer," or, "Instead of a CT without contrast, there was a decision to add CT with contrast," says **Sheila Holzman**, RN, CHAM, manager of the scheduling office at Mercy Medical Center in Baltimore. Although registrars don't always use these exact words, says Holzman, they convey this information to patients: "Final charges for one's planned procedure may vary, because your final charges are determined by the personalized medical care that you receive. Many times your doctor will make decisions to modify they type of services, procedures, and/or medical supplies you receive based on what your doctor determines is medically necessary for your health and well-being. Even seemingly minor changes in the procedure can cause charges to vary substantially from the estimate. Often, there is no way to predict these changes until your treatment is underway."

"One can't always predict the exact surgery or procedure," says Holzman. "Healthcare doesn't work that way."

To avoid misunderstandings involving incorrect estimates, take these steps:

1. Take extra time to inform patients about other bills they might receive from the anesthesiologist, radiologist, pathologist, or surgeon.

"Patients may assume quoted charges are the only charges they will owe," says Andres. "They aren't aware of the difference between facility and professional charges, and how many of those can be included in just one procedure."

2. Ensure that staff members use appropriate scripting at the time the estimate is given.

Otherwise, patients might not understand that there could be a difference from the original quote. "If there are additional monies due, the patient will accept and understand the new numbers," says Andres.

3. Honor original estimates if an error was made.

"Unless there is a major discrepancy in the estimation and what the actual charges turn out to be, we honor the original estimate if the patient is insistent," says Andres. "If it is a large sum, we offer a discounted rate on the difference." ■

Denials cut from $200K to $50K

Requirements surge demands new processes

Because the findings were unclear on an abdominal and pelvic sonogram performed for a patient at Cook Children's Medical Center in Fort Worth, TX, the radiologist performed a CT scan of the abdomen and pelvis with contrast, but this additional test hadn't been authorized by the payer.

Andrea Ayala, financial counselor for patient registration, successfully requested a retroactive authorization, because the test was performed only a day earlier.

"Had this not been approved, it would have resulted in $4,867 in denied charges," says Ayala. "Denials for scheduled tests are now very rare. Thankfully, we have seen these decrease greatly."

High-dollar procedures such as magnetic resonance imaging (MRI) were frequently denied due to no authorization, she says. "This was despite the efforts by our insurance team and referring physicians to have authorizations in place by the time of service," says Ayala.

Staff confirmed the accuracy of the CPT code, facility location, national provider identifier, Texas provider identifier, tax identification number, and valid date span, says Ayala, but this effort didn't address the reason for most of the denials.

Annual claims denials decreased from $200,000 to $50,000 at Cook Children's in the past year because of changes made to address these underlying reasons for denials:

- The provider recommended another type of study after a different test was already authorized by the payer, or added contrast materials to a pre-approved test.

"This is often done once the patient has presented for testing and may be due to noted abnormalities," she explains.

- The referring provider added the test, but failed to notify his staff responsible for authorizations of requested orders.
- New patient registration was unaware that insurance must be verified before the patient is sent for high-tech imaging outside normal business hours.
- Approved studies were changed to a more appropriate test by radiology, but the insurance team and referring provider offices were unaware of the changes.

Verbal communication about the change sometimes took place between the radiologist and the referring provider, or another type of diagnostic test might have been done because the radiologist was unable to obtain clear findings, but the denials still occurred, says Ayala. "In many cases, the insurance will not pay for anything else than the specific CPT that was approved," she says.

Communication revamped

Members of the radiology staff now notify patient access staff of same-day changes for high-tech imaging, says Ayala. Some commercial insurance and Medicaid managed care plans refuse to revise an authorization even if it's called in the day after the test is performed, she says.

"This could result in claims denial of the approved test in its entirety. We must make every effort to communicate changes that same day," she says.

Ayala obtains same-day email notifications of MRI and CT order changes with the patient's account number. "This helps me to review the account quickly, to initiate communication with the carrier," she says.

EXECUTIVE SUMMARY

New processes are needed to avoid "no authorization" denials for high-dollar procedures. Use these approaches:

- Identify underlying reasons for denials.
- Have radiology notify you of same-day changes.
- Compare authorized CPT codes to actual studies performed.

(See related story, below, on how daily reports are used to reduce denials, and see story, right, about how a pre-arrival unit reduces claims denials.)

SOURCE

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Radiology reports eliminate 'no auths'

Radiology managers at Cook Children's Medical Center in Fort Worth, TX, now create a daily report for all of their scheduled patients, which gives the patient name, account number, a description of the test, and the payer. The goal is to eliminate claims denials for high-dollar procedures.

"These accounts are worked in advance by our insurance team," says **Andrea Ayala**, financial counselor for patient registration. "I run this report each morning to review the prior day's registrations. I compare the CPT codes authorized with the actual study that was performed."

The reports identify the CPT approved by the carrier and the actual CPT performed, including last-minute add-ons who bypassed the scheduling and insurance team.

"This has been extremely helpful in requesting appropriate authorization prior to the claim billing, thus never getting a rejection and delaying payment," says Ayala.

For example, if a magnetic resonance imaging (MRI) of the brain without contrast (CPT 70551) was approved by the payer, the report might indicate that an MRI of the brain with or without contrast (CPT 70553) was performed instead. "In this case, it would be a denial if it was not retroactively approved by the insurance," says Ayala. "I would follow up with the carrier to request the revision."

Radiology creates a second report of radiology patients who were registered the previous day, but were unscheduled by mistake. This report catches any patients that have bypassed the insurance team and physician referral coordinator, so that retroactive authorizations can be obtained, says Ayala.

"Currently, I review about 50 scheduled radiology tests performed the day prior for changes. The non-scheduled tests average about 44 patients daily," says Ayala. ■

$325,000 in charges is paid due to process

Pre-arrival nurse acts as liaison

Until recently, the authorization process for imaging services was fairly simple, but this situation is no longer the case, says **Hope Johnson**, RN, the pre-arrival unit nurse at University of Mississippi Health Care in Clinton.

"Payers are now enforcing more stringent guidelines and criteria for authorizing services, including procedures that may be considered routine," says Johnson.

A pre-arrival unit was created at University of Mississippi in 2010, to financially clear patients. To date, $325,000 in charges were paid for services as a result of the unit's efforts, which might otherwise have been denied, reports **Sylvia Greer**, MBA, associate director of revenue cycle management.

"We now have people who are dedicated to proactively obtaining these authorizations," says Greer. "We are usually two weeks out in the imaging area. Now the clinics can provide patient care, while we take care of the authorizations."

Patient accounts handled by the pre-arrival unit were denied for non-coverage or no authorization less than 1% of the time in 2011, adds Greer.

Clinical info provided

Johnson acts as a liaison between payers and physician offices, to ensure that whatever clinical information requested by payers is provided.

"Payers may ask for pathology reports, X-rays, clinic notes, or labs," says Johnson. "We make sure the office realizes how important it is to give this information, so the patient is not responsible for the bill."

If a magnetic resonance imaging (MRI) of the lumbar spine is ordered, for example, the payer might request proof that the patient has tried multiple other treatments including pain management and physical therapy. "They want to know, 'Has the patient tried everything else prior to getting this MRI?'" All of that information isn't always in our charts. The patient may have gone somewhere else for physical therapy, so we will have to contact the office for those records," says Johnson.

If the payer's physician wants to speak peer-to-peer with the patient's physician, Johnson facilitates those conversations. "All the notes may be in there, but the doctor from the insurance company wants to discuss the reason a test is being ordered with the physician," she says. "Most of the time when they talk, the case is approved." ■

Can you text patient about appointments?

Patient privacy is biggest obstacle

Many patients are accustomed to receiving text messages from friends, retailers, and workplaces, and they probably expect to be able to receive texts from you.

"We've taken proactive steps to accommodate our patients in this way," says **Brian A. Todd**, CHAM, manager of patient access staff development and training at Lourdes Health System in Camden, NJ. "In fact, we have some of this communication already in place."

These steps occur when patients go online and request their own appointments on the hospital's website:

• Once the request is submitted, the scheduler schedules the patient without the need for a phone call.

• The patient receives an email with a link to view the scheduled date, time, and procedure-specific instructions.

"Our patients who choose a more traditional method of scheduling, via the phone, also have the opportunity to receive their appointment instructions via email, as well as an appointment reminder two days prior to the procedure," says Todd.

Text messaging is the next step, says Todd, adding that he envisions his patient access department texting patients to remind them that a payment plan bill is due, and emailing consent forms so that patients can read and review them carefully before signing. "In this day and age of smart phones, the goal is to keep the patient informed while they're on the go," he says. "Keeping the patient well-informed while being brief and succinct is a challenge; 160 characters only goes so far!" Todd recommends considering these items:

• Patients might be annoyed if they receive what they consider to be too many text messages.

"There's the balance of keeping the patient informed, while not bombarding them with message after message," says Todd. "The last thing we want to do is desensitize them to our message."

• Patient privacy regulations must be complied with.

This area is the biggest obstacle for patient access areas to overcome when texting patients, according to Todd. "You want to make sure you're compliant at all times. Ensuring you're securely communicating [protected health information] with your patients is paramount," he says.

One approach is to provide a link to a secure database so patients can validate their identity before disclosing information. "Obtaining consent to communicate with a patient in this way is crucial, especially when establishing a text communication," says Todd.

• Consents should be revisited and updated at regular intervals.

A confidentiality breach could inadvertently occur if patients change their mobile phone number or hand it off to a friend or family member, without informing their providers, explains Todd.

"Having a way for the patient to communicate back to a patient access representative, should this become necessary, is also something to think about," says Todd.

• Patients might have questions about the initial email or text sent by patient access.

Your system should guide the patient to call a patient access representative instead of emailing questions, recommends Todd.

"This limits the amount of 'back and forth' emails. It mitigates the responsibility to constantly man an inbox," he says. *(See related story, p. 44, on implementing texting in patient access areas.)*

EXECUTIVE SUMMARY

Patients will expect to receive emails and text messages about appointments, but this presents challenges for patient access. Take these steps:

- Revisit and update consents at certain intervals.
- Build a database of patients who wish to receive emails and texts.
- Text patients with general reminders and send emails for patient-specific matters.

SOURCE

For more information on texting and emailing patients, contact:

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Piloting texting? Here's how to start

If you want to begin texting and emailing patients, the easiest way to start is to replace a current communication process, according to **Brian A. Todd,** CHAM, manager of patient access staff development and training at Lourdes Health System in Camden, NJ.

For example, a registration area could text or email patients about an appointment for a scheduled procedure. "You potentially could start with a reoccurring patient population to ensure the kinks are worked out. That feedback will be readily available to you," says Todd. "Once that is done, advancing to include a larger population should be a breeze." He recommends taking these steps:

1. Identify which patients wish to receive texts and emails from your patient access department.

"There is a specific patient population that would utilize and truly appreciate these services," says Todd. "Being able to identify this target audience becomes key."

2. Build a database of email addresses and mobile phone numbers.

Obtaining this information at all registration areas would be ideal, says Todd, whether that type of registration would warrant this type of communication or not.

"This is where the IT folks come into play, in building a field to make this possible," says Todd. "Finding a vendor to facilitate this type of communication might also be an alternative."

3. Identify the types of communication you'd like to establish.

It might be that you are sending "save the date" information to all patients, or you might be looking to target specific groups of patients.

"This is where meeting with the clinical folks may come in handy, to find out what would they like to communicate to patients," says Todd. "Collaborating with IT to make this truly happen falls right in line at this point."

4. Keep risk management and corporate compliance associates informed and in the loop.

"It's easy to step over the compliance line and not even know it," says Todd. For example, a registrar might send a non-secure email including patient-identifying information in the body of the message.

"This could pose a compliance breach," Todd says. "To overcome this, having a patient log in to a secure database to view their information is a viable option."

5. Begin by sending emails alerting patients to health fairs sponsored by the organization or annual flu vaccine availability reminders.

"Hopefully before a blast email is sent, glitches will have been identified and mitigated," says Todd.

6. Send text messages for general communications, and send emails for patient-specific messages.

"The key to keep in mind when developing these types of communication is, 'What do you ultimately want to accomplish?'" says Todd. "If it's just a general reminder, text it. If it's something more involved, email it securely." ■

Access descriptions are likely outdated

Update with new skills

Until recently, members of the patient access staff at St. Joseph's Hospital Health Center in Syracuse, NY, were assigned a generic "customer service representative" title that didn't reflect what they actually did.

"The title was used for multiple departments who had a variety of job functions, many that were not related to patient access functions," says **Carol Triggs,** MS, director of patient access.

In 2001, a separate job description was created for patient access representatives to accurately reflect the skill sets, training, functions, and responsibilities required of patient access staff. For example, members of the access staff are required to be proficient in multiple software systems.

In addition, every area of patient access has a specific job description tailored to the actual daily functions specific to their area, explains Triggs. For example, centralized scheduling or pre-registration job criteria are different than the job criteria of an ED patient representative. "We wanted to ensure that their job functions were accurately compared during the compensation surveys performed by human resources," Triggs says.

EXECUTIVE SUMMARY

Patient access job descriptions are often outdated, which can cause problems with hiring, salaries, and evaluations.

- Update job descriptions to include current skill sets and training.
- Tailor job descriptions to specific areas of access.
- Offer more pay for specific certifications.

Obstacles with evaluations

If patient access job descriptions are outdated, these no longer will cover job expectations when you complete performance reviews, warns **Wendy M. Roach**, RDMS, manager of patient access and central scheduling at Advocate Good Shepherd Hospital in Barrington, IL.

For example, an associate might be required to attend 75% of staff meetings annually. If that expectation is not listed on the job description and is not included in signed department guidelines, it can be difficult to hold associates accountable for meeting the criteria, says Roach. "If you are adding 'Did not meet the requirement to attend 75% of staff meetings' to the performance review, it becomes the 'It's not in my job description' scenario," says Roach.

More pay for access

"The requirements included in a job description will determine the pay scale for the position," says Roach. "Adding or taking away one thing can really make a difference." For example, the pay scale goes up if a staff member obtains certification as a certified healthcare access associate.

"When you add in different requirements, you can then develop tiered job descriptions," says Roach. "This is something that we are in the process of developing."

A Tier 1 description is for a basic registrar with no certification and works only in one area, while a Tier 2 description is for a registrar that has certification, can precept, and can work in more than one area, she explains.

"As the requirements increase, the pay increases," says Roach. "If descriptions are not current, there is a potential concern of not being competitive with your market." *(See related stories on utilizing job descriptions when hiring, right, and how job descriptions can affect the ability to evaluate staff, right.)*

SOURCES

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Obtain higher level of access applicants

Updated job descriptions in your patient access department will attract a higher level of applicants who are more likely to meet your expectations, according to **Carol Triggs**, MS, director of patient access at St. Joseph's Hospital Health Center in Syracuse, NY.

"We have increased recruiting efforts this past year for our newly expanded ED," she reports. "Having a new job description which clearly outlined the requirements, functions, responsibilities, and necessary training was very helpful."

Triggs adds that she would not have been able to set realistic performance expectations for an applicant otherwise, and applicants wouldn't have a clear understanding of the position.

Up-to-date job descriptions can help you hire quality associates who are meeting industry norms, says **Wendy M. Roach**, RDMS, manager of patient access and central scheduling at Advocate Good Shepherd Hospital in Barrington, IL. "This allows us to continue to be financially competitive with our market," Roach says. "We can identify required expectations that we can then hold staff accountable for." ■

Inaccurate description of access is costly

Evaluations, hiring are problematic

Several years ago, it was becoming painfully obvious that registrars at Emory Hospitals in Atlanta deserved a pay increase due to their expanded responsibilities, reports **Ramon Velez**, director of patient access. However, their job description posed an obstacle.

"It was unfair, because the front end was doing a lot of work that used to be done on the back end," he says.

The problem was that access representatives' job description was outdated, reflecting an entry-level position that primarily was responsible for data entry at the time it was written, says Velez. "It was obvious we had to pay them more money," he says. "If not, that same person would prefer working in the business office where they would be paid more."

To avoid losing staff to other areas of the hospital, a decision was made to give the patient access employees the same job description as the business office staff, so

they would be paid on the same scale, says Velez.

"We transitioned our access folks to a patient accounting job description, in order to get them more money," he explains.

Evaluation is difficult

However, the continuing expansion of the access role at Emory Hospitals has led to some problems evaluating employees.

"The problem we are confronting now is that what access and the business office do is totally different," says Velez.

Managers are finding it tough to evaluate staff on key functions of their job, such as customer service, since these aren't included in the job description. "That means that evaluations tend to be a little more subjective. It is more difficult to say to an employee, 'You aren't meeting that standard,'" says Velez.

Providing excellent customer service has become a top priority for access staff, for example, but this isn't part of the job description of business office staff. Velez also needs applicants who can handle financial counseling and insurance verification.

"I tend to look for an employee with a mixture of healthcare experience and some type of customer service or retail experience," he says. "None of that is in the current job description."

It also makes it difficult to find qualified applications for access positions, which costs the hospital more in the long run, says Velez. "Cleaner information is required on the front end," he explains. "If you hire somebody with less know-how, you will have to QA their work extensively to make sure you are billing appropriately."

Velez is working with human resources staff on updating the job description of access staff to reflect these realities.

"In the old days, you didn't need healthcare experience, because all you were doing was key punching," he says. "Now we need someone who can handle collections while maintaining a high level of customer service."

The department is switching to centralized scheduling, which will call for cross-training and additional skill sets, says Velez. "It will be a one-stop shop," he says. "We will schedule the patient, take their demographic information, and verify insurance, all at one time."

This change means the access representative job description will need updating again, says Velez.

"We've all been under pressure to maintain or reduce FTEs as the reimbursement model continues to change," he says. "When people call out or take vacations, we'll be able to pull staff from another area. Instead of having 200 employee in silos, we can use them across the whole system." ■

Patient questions are getting tougher

Training has 'huge impact' on bottom line

"Will my insurance cover this visit?" is something patients often ask registrars in the emergency department at Sutter Delta Medical Center in Antioch, CA. However, the answer isn't as simple as it seems.

"This is a very common question, but we cannot provide a yes or no answer to patients," says registration manager **Chris Hatcher.** Instead, patient access staff are instructed to inform patients that all insurance vendors are billed, whether they are listed as a contract provider with the hospital or not, because payment is based on the patients' coverage and how their insurance policy determines emergent care services needed.

"Patient access clerks also receive questions related to charity care — how does one apply and how to qualify for the program," says Hatcher. These steps were taken to help staff provide accurate answers:

• Registration clerks use a script with responses to the most commonly asked questions.

"As staff brings to our attention new questions they receive from patients, we adjust our reference tool," says Hatcher.

• Staff members are instructed to contact the insurance provider with the patient present, if there are questions about coverage.

"Everyone can hear the same message. This helps eliminate any misunderstandings that could occur," says Hatcher.

Affects bottom line

Registrars at Skaggs Regional Medical Center in Branson, MO, attend quarterly training sessions to gain skills in answering difficult questions, says **Rebecka Sandy**, CHAA, CHAM, outpatient financial counselor team lead.

"Access supervisors from registration, centralized scheduling, and financial counseling all provide the quarterly training," says Sandy. "The training sessions are given in one-hour sessions to include almost all shifts."

Recent topics have covered scripting for upfront collections, setting up payment plans, and preventing insurance denials. *[The computerized graphic presen-*

tation used by Sandy for training in upfront collections and payment plans is included with the online version of this month's Hospital Access Management. *Go to http://bit.ly/zvOgxQ. On the right side of the page, select "Access your newsletters." You will need your subscriber number from your mailing label. For assistance, contact customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Registrars learned the reason for recent claims denials, including a patient who had coverage with a Medicare HMO, and another patient whose name in the hospital system didn't match Medicaid's system. "All of these denials could have been prevented by properly reading the electronic eligibility," says Sandy, adding that additional training was provided to address this need.

If registrars are able to educate patients about insurance benefits and financial obligations, this helps them to know what to expect both during the present visit and future visits, says Sandy. "Without question, training access representatives to field a variety of questions has a huge impact on the hospital's bottom line," she adds. "If the patient is satisfied, they will not only use your facility, but will also recommend it to others," Sandy says. *(See related story, below, on common questions from patients.)*

SOURCE

For more information on responding to patient questions, contact:
- **Chris Hatcher**, Registration Manager, Sutter Delta Medical Center, Antioch, CA. Phone: (925) 779-7249. Email: HatcheC@sutterhealth.org.
- **Rebecka Sandy**, CHAA, CHAM, Outpatient Financial Counselor Team Lead, Skaggs Regional Medical Center, Branson, MO. Phone: (417) 348-8930. Fax: (417) 348-8029. Email: resandy@skaggs.net. ■

Be ready to answer all these questions

Here are some questions patients are asking registrars at Skaggs Regional Medical Center in Branson, MO, and what managers are doing to help staff to respond:

1. "Will my insurance cover this?"

"Registrars need to understand the basics of how health insurance works, and the terminology used, in order to better educate the patient," says **Rebecka Sandy**, CHAA, CHAM, outpatient financial counselor team lead.

Understanding insurance terminology is especially crucial when members of the front end staff are answering questions about benefits, she explains. "Typical concerns of patients are things such as what differentiates a copay from a coinsurance, or what constitutes an out-of-pocket maximum," says Sandy.

2. "Do I qualify for financial assistance?"

"Providing a few key questions for front-end staff to interview the patient can help them easily identify if the patient may be eligible for the financial assistance program," says Sandy. Registrars ask these questions:

- Do you currently have health insurance coverage, or are you eligible for any type of health coverage?
- Are you employed?
- If you are not employed, what has kept you from employment? Is it a health-related issue?
- How many people are there in your household?
- What is your estimated household income?

3. "What does my Medicare coverage include?"

Patients often are confused about their Medicare coverage, especially those new to Medicare, says Sandy, and many don't know the difference between Part A and Part B coverage.

Registrars might have trouble identifying when a patient has an additional payer, such as a Medicare Advantage plan or large group health plan coverage, says Sandy. She encourages her staff to use free web-based training available from the Centers for Medicare & Medicaid Services' Medicare Learning Network. *(For more information, go to https://www.cms.gov/MLNProducts/03_WebBasedTraining.asp. Under the heading "Related Links Inside CMS," click on "Web-based Training (WBT) Courses.").*

"Many members of the staff have taken advantage of this. This is a great tool to prepare for the [certified healthcare access associate] exam," she adds. ■

Is insurance valid? Process is high-tech

Not long ago, a registrar would assume a patient was providing accurate information, only to find out the claim was denied due to incorrect insurance, reports **Michelle M. Mohrbach**, CHAM, manager of patient access and central scheduling at Blanchard Valley Health System in Findlay, OH.

COMING IN FUTURE MONTHS

- Audit access areas to stop unintentional fraud
- Cut costs in your department by going paperless
- Give provider's offices a reason to choose your hospital
- Make physicians your allies in getting authorizations

"Sometimes patients would present with two or three card choices, because they were hesitant to throw any away," she says."With the software that's available now, you can know in a matter of seconds if the patient has active coverage."

At one time, says Mohrbach, registrars had to be familiar only with Blue Cross/Blue Shield, traditional Medicare, traditional Medicaid, workers' compensation, and automobile insurance.

Today's registrars deal with preferred provider organizations (PPOs), health maintenance organizations (HMOs), managed care organizations (MCOs), and third-party administrators. "It's not unusual to have between four and six Medicare and Medicaid HMOs, along with the traditional option," says Mohrbach. "Patients can also elect to change every 30 days, making it more of a challenge for the registrar to stay on top of things."

Registrars sometimes pre-register a patient at the end of the month for a date of service the beginning of the following month, and find that the insurance already has changed. "We are constantly verifying benefits, both checking in real time and in nightly batches," says Mohrbach.

Online web access to payer sites means that registrars no longer need to spend hours on hold waiting to verify benefits. "Using online web access, they're able to find co-pay and deductible information in minutes, no matter what shift the specialist is working," she says.

Mohrbach's staff use verification software to identify active coverage, co-pays, deductibles, and out-of-pocket expenses, so they can tell patients what is covered and what they will be responsible for.

"Patients scheduled for high-dollar testing especially appreciate this information being provided to them prior to their visit," she adds. Registrars are able to offer payment options, prompt pay discounts, and screenings for the state's Hospital Care Assurance Program and charity program eligibility.

"By doing more screening and collections on the front end, we're helping to expedite the billing cycle," says Mohrbach. "We've found patients are more willing to talk before the service is received."

EXECUTIVE SUMMARY

Patients' coverage is continually changing, and there are far more payers for registrars to keep track of. To verify benefits:

- Use insurance verification software to determine the patient's responsibility.
- Have staff access information via payer websites.
- Identify active coverage, copays, and deductibles.

SOURCE

For more information on insurance verification processes, contact:
- **Michelle M. Mohrbach**, CHAM, Manager Patient Access/Central Scheduling, Blanchard Valley Health System, Findlay, OH. Telephone: (419) 429-7655. Fax: (419) 424-1864. Email: mmohrbach@bvhealthsystem.org. ■

Be empathetic not sympathetic

-understand the patient's situation, but pursue reasonable payment options with the patient.

-we **must** be sincere when empathizing with the patient.

Put yourself in the patient's shoes

-how would you want the situation explained, presented, and handled?

I have already met my out of pocket this year.

I understand Mrs. Smith & that is why we verify your benefits with your insurance carrier. They have stated that you have not met your out of pocket yet this year. We verify with your carrier in order to provide you with the most current coverage information. How would you like to take care of your coinsurance today? We accept cash, check and credit card.

I would like to wait until my insurance pays and then I will pay.

Unfortunately insurance rarely covers all costs. As a service to you, we've already verified your coverage benefits and your estimated portion due today is $____. How would you like to take care of that? We except cash, check and credit cards.

I have never had to pay before. Just send me a bill.

Since you were last here, we have made changes in our processes that no longer allow us to delay collecting copayments, deductibles, or coinsurance amounts. This helps to ensure that we keep medical costs down for everyone. By taking care of your portion now, you can avoid worrying about a bill later. Would you like to take care of that by cash, check or credit card?

I didn’t bring my wallet.

I understand Mrs. Smith. Do you have somebody that could bring it to you? I would be happy to call them for you.

I had a procedure (ER visit) here before and I didn't have to pay that much.

I understand Mrs. Smith. Prices & coverage can vary for each type of procedure. We verify your coverage and benefits with your insurance carrier each time in order to provide you with the most current information. Would you like to take care of that by cash, check or credit card?

There is no way I can afford this!

I understand that this is a sizable amount of money, but we do have a variety of payment options, many of which I can process right here for you.

PAYMENT PLAN MATRIX

The following installment matrix will be used to calculate the patient's monthly payment amount:

Total of Patient's Liabilities	Maximum Repayment Term	Minimum Monthly Payment
$50 and less	In Full	In Full
$51 – $100	2	$40
$101 - $300	3	$55
$301 - $600	6	$75
$601 - $1,200	10	$100
$1,201 - $3,000	12	$150
$3,001 - $6,000	15	$250
$6,001 and over	18	$350

SKAGGS | REGIONAL MEDICAL CENTER

Payment Plan Agreement

Effective Date: _____

Account Number: _____ **Patient Name:** _____

SSN: _____ **Phone Number:** _____

Personal Balance: $ _____

Payment Terms:

Payment Amount: **$** _____

Date of first payment due: _____

Plan Term (# of months): _____

I agree to the Payment Agreement terms stated above and understand that any additional unpaid charges accrued will result in adjustment of the payment amount to satisfy the plan term. If circumstances arise that I am unable to meet the terms as stated, I understand that it is my responsibility to contact Skaggs Customer Service @ 417-348-8620 to make other arrangements. I agree that if the account is placed for collection, to pay interest on all amounts due, calculated at the annual rate of 9%, as defined by Mo. Rev. Stat. 408.020, plus all collection agency costs, and reasonable attorney fees. I also agree to waive venue and do agree that any action filed to collect any amounts due for services rendered shall be filed in Taney County, Missouri.

Date: _____ **Signature:** _____ **Relationship:** _____

Date: _____ **Signature:** _____ **Relationship:** _____

Date: _____ **Witness:** _____

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$6,001 and over	18	$350

SOURCE: Skaggs Regional Medical Center, Branson, MO.