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IN THIS ISSUE

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Are access employees struggling with new skill sets? Don't let them fail

It's not one size fits all

Recent changes for patient access staff at BayCare Health System in Tampa, FL, include registration kiosks, palm vein biometric devices, and new consent forms that all patients have to sign.

Patient access staff members were trained on every one of these changes, but even experienced registrars needed one-on-one training in some areas, reports **Tammy A. Scott,** CHAM, a patient access service manager in the Emergency Center. To be sure staff can keep up with all of the new skills that are required, BayCare's Central Business Office offers training "far beyond the 'new hire' classes," she says, such as specialized classes on cash collections and insurance verification.

"Many healthcare systems are experiencing a decrease in patient volume. When patient volumes drop, so does the need for FTEs," says Scott. "Staff are doing more with less, and without sacrificing quality."

Multi-generational training

"People are working later in life today, for myriad reasons. In just a few years, most companies will be employing five different generations," says Scott.

"One-size-fits-all" training isn't enough anymore for today's patient access departments, she argues. "Without understanding how each generation learns and what motivates them, you cannot form a viable training program," warns Scott. "Ultimately, you will increase your turnover rate."

Scott says the vast majority of her Generation X team members prefer

EXECUTIVE SUMMARY

Multigenerational employees, expanding roles, and decreasing volume all result in the need for individualized training of patient access staff.

- Offer both hands-on and classroom learning.
- Ask experienced staff members to help with difficult registrations.
- Assign a mentor to staff members needing improvement.

hands-on "social learning" over attending lectures, while most baby boomers want some traditional classroom training before they perform a given task.

"Once they feel comfortable, they want to be left alone to do their work," she says. "However, the nature of our industry is constantly changing. The baby boomers are adapting to 'social learning' more as time goes by."

Scott includes more than one approach in her training, to appeal to different learning preferences. The 12-day program is taught by full-time training specialists at BayCare's Central Business Office and covers insurance, compliance, patient satisfaction, documentation, cash collections, and scripting. "Staff do not just sit and listen to instructors. They role play, practice 'live' registration, and play games involving compliance issues," Scott says.

Next, each team member is paired with a more experienced employee who can help with complicated registrations such as trauma patients and also guide them through "'off-the-wall' scenarios that don't happen every single day, she says. "It may not be an extremely common case, but it does happen," Scott says. "It is easy to forget the process to handle them."

For example, a new team member probably would need guidance registering a 65-year-old man who was hurt driving a company vehicle, with both managed care insurance through his employer and Medicare coverage. "Once team members feel ready to be on their own, they are then set free," says Scott. "It does not stop there, either. Each team member's work, regardless of tenure, is quality-checked every day."

More multitasking

Even the most talented patient access employee struggles with new skills at times, says **Cynthia Norman-Bey**, director of patient access services and the PBX (private branch exchange) Call Center at Glendale (CA) Adventist Medical Center.

Norman-Bey has seen experienced registrars find it difficult to protect the hospital's bottom line by ensuring that cash collections occur appropriately, while at the same time respecting the fact that a particular patient is struggling financially, for example. *(See related stories on how to train staff on new skill sets required in patient access, p. 75, and evaluating why an employee is struggling, p. 75.)*

Here are strategies Norman-Bey uses to individualize training for patient access staff:

• During weekly quality assurance meetings, patient access supervisors review the performance of staff, with a particular emphasis on customer service.

If Norman-Bey thinks there is a need to have more than one meeting a week regarding a particular employee's performance, then one-on-one mentoring is provided. "Service excellence then becomes the norm," she says. "I believe that providing a mentor to staff is the best, least costly, and most effective training."

• Individualized training is developed by supervisors, based on daily quality assessments conducted for each employee in the department.

"Our department is a high-level call center that provides a multitude of services for both internal and external customers," adds Norman-Bey.

Staff members look at actual scenarios of the best service provided in the department and the "not-so-good service," she says, and they identify what could

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have raised the bar to better service, she says.

• The department invested $1,500 in customer service training DVDs.

"We require our staff to view these on a monthly basis," Norman-Bey says. "We review and discuss the DVD at each monthly meeting, emphasizing key service points."

SOURCES

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Registrar isn't up to par? Ask this

Have a staff mentor assist

Is an employee simply unable to keep up with the workload? Or is the employee simply not suited to working in a department where expectancy of service excellence is a requirement?

These are the two questions **Cynthia Norman-Bey**, director of patient access services and the PBX (private branch exchange) Call Center at Glendale (CA) Adventist Medical Center, asks if she notices a particular patient access employee is struggling with the skills required.

"Everyone learns differently and at their own pace," Norman-Bey says. "We make allowances for what we believe to be challenges with learning. We start them off slowly and ask others in the department to assist them whenever needed."

It helps that some of employees who now act as mentors were struggling at one point in time themselves, she adds. "So far, this method has helped build teamwork and not resentment. This is because out of the staff that is assisting, there is at least one or two of them that started out the same way," Norman-Bey explains.

However, no supervisor can afford to continue to support an employee who simply can't provide excellent service, she says.

"If your business revenue is to continue to grow, then maintaining a service excellence reputation is critical to that success," she says. "Any employee that cannot support that criteria should be counseled out of the position." ■

Train staff in these 3 skills

The single biggest challenge for registrars is all the multi-tasking they need to do, according to **Cynthia Norman-Bey**, director of patient access services and the PBX (private branch exchange) Call Center at Glendale Adventist Medical Center.

"Tasks are all equally important, and all require that courtesy of services remains a primary focus," Norman-Bey says. Here are three key areas to focus training on:

• The assertiveness required to obtain authorizations.

At OSF Healthcare System in Peoria, IL, staff members struggle with being assertive enough to deal with "push back" from insurance companies and physicians in order to put the necessary authorizations in place, says **Luka Krietemeyer**, patient access services manager of the financial Clearance Center/Patient Accounting and Access Center.

"It is a delicate dance at times, to make sure all three entities are on the same page," Krietemeyer says. "All of the appropriate requirements need to be met, to optimize patient coverage and reimbursement."

• Familiarity with new terminology.

New patient access hires will need to become familiar with the meaning of dozens of terms used for authorizations and benefits, such as "precertification," "referral," "Radiology Quality Initiative," and CPT codes, says Krietemeyer. "This is a struggle for some staff initially," she adds. "But as they work the same types of appointments repeatedly, the terms start to become part of their normal process."

• New processes for obtaining consent for treatment.

Registrars at BayCare Health System in Tampa, FL, recently had to become accustomed to a new process involving consent for treatment. Every patient, with the exception of pediatric and psychiatric patients, now has the option to sign a consent for treatment during each visit, or they can choose to have a "lifetime consent" on file, says **Tammy A. Scott**, CHAM, a patient access service manager in the Emergency Center.

However, in order for the signed consent to follow the patient throughout any of the health system's inpatient or outpatient facilities, it needs to be electronically signed and stored at the Corporate Identifier Number level. "It is not uncommon that during a registration,

the registrars must place some signatures in multiple folders within our electronic scanning system," says Scott.

Most patients choose to sign the lifetime consent, which requires the registrar to store the electronic signature differently, she adds. "This new initiative was a major change to the workflow process that the registrars previously used," says Scott. "Until now, all electronic signatures received were stored at the visit level." These steps were taken to train staff:

• Registrars attended a mandatory webinar on the new process.

• Trainers, managers, and registration coordinators watched the registrars complete registrations.

"They made sure they had a full understanding not only of which forms go into which file, but also the importance of why the consent needs to be separate," says Scott.

• All registrations were audited.

"We reported all of the errors for this new process," says Scott. "We could see exactly who needed more time with a trainer, manager, or peer." ■

Patients will expect same-day scheduling

They're willing to go elsewhere

"Can I get this diagnostic test done here today?" If the answer to this question is "no," the patient standing in front of you might go elsewhere for services, warns **Jennifer Nichols**, director of patient access at Spectrum Health in Grand Rapids, MI, where same-day scheduling is now offered to radiology patients.

"We are seeing that patients are willing to go to other locations if they can be seen sooner," says Nichols. "They will often call multiple hospital or service providers."

Patients are become increasing sophisticated consumers, and they understand that their physician's order possibly can be fulfilled at many locations, says Nichols. "In addition, provider offices prefer this option," she says. "They are eager to have the diagnostic results back in order to proceed with patient care."

Hospitals must compete with stand-alone facilities that offer patients appointments when they want them, says **Wendy M. Roach**, RDMS, manager of patient access and central scheduling at Advocate Good Shepherd Hospital in Barrington, IL. "Patients want appointments to meet their needs and their schedules," Roach says. Consider taking these steps before offering same-day scheduling:

• Get support from the imaging leadership team.

"This smooths the transition of adding onto an already filled schedule," says Roach. To accommodate same-day appointments, imaging departments must work around their currently scheduled outpatients, "stat" add-ons, emergency patients, and inpatients, she explains.

• Be sure staff members obtain a valid and appropriate provider order prior to the procedure.

Because patients often carry in a written order for a diagnostic test, clinical staff must be aware of the organization's requirements for a valid order, says Nichols.

"Some items are federally mandated, like prohibiting the use of certain abbreviations. Other items may vary by hospital, possibly," she says. "Staff need to ensure that they have those elements present and legible."

• Have items on hand for service recovery.

"Even with the best intentions and plans, you might have patients that will wait longer than expected," says Roach. "Having a gift certificate or gas card to give them is a necessity." Patient access staff members typically give patients a $25 gas card, she adds.

• Develop a strong partnership between patient access and clinical care teams.

At Spectrum Health, members of the radiology department and the offsite central scheduling team collaborate in making any necessary adjustments to accommodate a patient. Recently, radiology staff members agreed to convert two existing slots on the day's schedule into a single slot, so a lengthier procedure could be scheduled, for example.

"We have a clear culture of never turning a patient away, and accommodating same-day needs," says Nichols. "We also have highly responsive middle and upper leadership for escalation."

• Carefully review schedules and slots.

"Understand the types of same-day visits that the department is anticipating," says Nichols. "Build access to those types of visit slots in advance of deploying such a program." *(See related stories, p. 77, on obtaining authorizations for same-day scheduling,*

EXECUTIVE SUMMARY

Patients now expect same or next-day scheduling for diagnostic tests, and they might go elsewhere if this option is not available. To avoid problems:

- Obtain support from clinical leadership.
- Offer gift certificates if long waits occur.
- Work with provider offices to obtain authorizations.

and unique challenges for collecting with same-day services, this page, right.)

SOURCES

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No authorization for same-day service?

Authorizations for high-dollar diagnostic tests are the single biggest problem with same-day scheduling, according to **Wendy M. Roach**, RDMS, manager of patient access and central scheduling at Advocate Good Shepherd Hospital in Barrington, IL.

If patients are scheduled for a test the same day or the next day, physician offices don't have enough time to complete the pre-authorization that is required, in part because payers are asking for clinical information.

"We would be happy to complete the pre-authorization, but insurance companies are requiring the physician offices to provide the patient's history along with signs and symptoms," Roach says.

Because of this situation, about 10 patients are being rescheduled every week at Advocate Good Shepherd Hospital. "This becomes not only a patient dissatisfier, but also something that is difficult on your bottom line," says Roach. "In some cases, we write off the amounts."

These steps now occur for same day scheduling:

• When schedulers put the appointment in the system, they send a fax to the provider's office informing them of this appointment.

"The biggest challenge is that the physician office is required to complete the process," says Roach. "A lot of the time, they do not have the manpower to complete it in a quick window."

• A fax is sent to the pre-certification department for follow-up.

"If the patient is same-day or next day, we indicate that on the top of the fax so that it is easily identified," says Roach.

• The pre-certification department contacts the physician office to follow up.

"Scheduling is not the issue. You can always manipulate what you need to squeeze a patient in," Roach says. "But if you don't get the authorizations, you could be writing off more then you planned."

Time carefully

Because authorizations usually require clinical information that the scheduler doesn't have access to, the process often needs to be originated by the ordering provider office, explains **Jennifer Nichols**, director of patient access at Spectrum Health in Grand Rapids, MI.

"This must be timed carefully to be done in advance of the service, or options for retro-authorization should be identified in advance with payers," says Nichols. "Some may allow retro-authorizations based on specific thresholds or medical necessity."

Typically, an authorization is requested by the ordering provider's office, as it requires information from the medical chart, and the authorization is then verified by the scheduling team.

"We may update it if necessary. For example, some authorizations list the service location, so we may need to enter in a different location the service will be provided at," says Nichols.

'Same day' means less time to collect

There is not only less time to collect the patient's out-of-pocket responsibility if a service is scheduled for the same day; there's also less time for the patient to make an informed decision if needed, says **Jennifer Nichols**, director of patient access at Spectrum Health in Grand Rapids, MI.

If a particular patient has a $50 copay at an in-network location, but has a $500 out of pocket at an out-of-network location, for example, that information is important for the patient to know.

"Staff should be given the tools and taught to provide this information," Nichols says.

With same-day scheduling, the challenges of collection typically are related to the amount of patient responsibility, says Nichols. "Our mechanisms for accepting payment are the same. But if the patient responsibility is large, it may not be something the patient is able to pay the same day," she explains.

Spectrum Health provides average charges on its website for its most common procedures. "We also provide a custom out-of-pocket calculator to determine patient liability for Spectrum Health patients with Priority Health coverage," says Nichols. "This takes into account current statuses of things like out-of-pocket maximums." ■

Stop denials for 'notice of admission'

If a patient is admitted at 10 a.m. Friday to Virtua Hospital in Marlton, NJ, members of the patient access staff have only until 10 a.m. Saturday to notify the insurance company.

"Previously, we had until the next business day, but we now have just 24 hours. Many of our insurance companies are really holding us accountable to that 24-hour mark," says **Diane E. Mastalski**, CHAA, CHAM, director of patient access. "When this occurs, it creates problems for many departments throughout the organization."

Tighter timeframes meant a major change in the role of Virtua's admission registrars, who are now responsible for notifying the insurance companies, instead of the insurance verification/financial planning team, she says. All admission registrars now complete the process for any patient they admit, which streamlines the process, Mastalski explains.

"In the past, we had to call each one in and give the insurance company the information. That meant waiting on the telephone and trying to get through," she says.

Most payers now accept electronic notification, adds Mastalski, and Horizon New Jersey Blue Cross/Blue Shield is set up to transmit the notification automatically through the electronic data interchange. "This speeds up the process for getting the information to the insurance company," says Mastalski. "However, we still have to wait for the authorization number, and that can take a day or more."

For this reason, members of the patient access staff are assigned to monitor the transmission reports from the hospital systems to the payer. "If a transaction kicks for any reason, that person is responsible to determine the cause and get the transaction resent," she says.

Work with case managers

The department leaders are looking into the possibility of transmitting notification electronically to more insurances through one technology solution, rather than using multiple solutions, Mastalski says.

Staff compliance is monitored on an ongoing basis, as failure to notify the insurance company within the appropriate timeframe can result in loss of revenue in the form of denied patient days for no authorization, she adds. "We work closely with our case management department. They let us know when there are fall outs," says Mastalski.

Some commercial payers have changed their notification requirements for inpatient bed status, reports **Mary Frances Wood**, RN, appeals case manager at Cook Children's Medical Center in Fort Worth, TX. As a result, case managers now assist in the process for making timely notification to avoid penalties.

"We are now tracking the amount of time patients have been in-house," Wood says. "This provides us with a window to make notification if an observation patient meets inpatient criteria and needs to be converted to inpatient status."

EXECUTIVE SUMMARY

Payers are requiring notification of admission in shorter time frames, which requires revamped patient access processes. To avoid claims denials:
- Have staff monitor transaction reports.
- Work closely with case managers.
- Track the amount of time patients have been in-house.

SOURCES

For more information on preventing claims denials due to incorrect patient status, contact:
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Ask staff to flag problem applicants

After an applicant for an emergency department patient access position admitted she had difficulty multi-tasking, it became clear she really wasn't a good fit for the job after all, says **Ebony Seymour**, CHAM, manager of admissions and registration at Palmetto Health Richland in Columbia, SC.

Seymour didn't learn this directly, however; it was discovered during the department's "peer interview" process. Designated employees from different registration areas and shifts perform their own interviews with prospective applicants after completing a training course.

The peer interviewers ask applicants about actual situations they encountered and how these were handled, such as, "Tell us about a time when your quick response to a problem made a difference." "Once the interview is complete, the peer interview team makes the final decision on which applicant they feel will be the best fit for the team," she says.

EXECUTIVE SUMMARY

Having frontline staff interview applicants can identify potential problems that weren't apparent during the initial interview.
- Allow peer interviewers to make the final decision.
- Ask applicants to shadow experienced employees.
- Make customer service a top priority.

Several times, the peer interview group detected unfavorable characteristics in candidates that weren't identified in the initial interview, reports Seymour. "The initial interview with the hiring manager is normally more focused on the applicant's employment history," she explains.

Encourage feedback

When **Barbara Novak**, revenue cycle manager at Central DuPage Hospital in Winfield, IL, identifies what she believes is a strong prospective candidate for a patient access position, she does these things before making the final decision to hire:

• Novak asks him or her to "shadow" an experienced staff person.

"This gives the candidate the opportunity to assess if the position is the right match for him or her, as well," she says. One applicant decided she didn't want the job she'd originally applied for, for example, because she realized she wanted to have more direct contact with patients.

• Novak encourages staff to ask the applicant specific questions.

Staff ask applicants, "Do you have any questions for me about the role?" and "Now that you've seen some of the patient encounters, what do you feel are the most important parts of the registration encounter?"

"What we're seeking is a focus on customer satisfaction, as well as accuracy of the registration," says Novak.

• Novak encourages feedback.

On one occasion, she decided not to hire an applicant because staff told her she seemed disinterested in the job. She typically asks her staff whether the applicant displayed professionalism and possessed good customer service skills, based on the brief time he or she spent in the department.

"The staff feel they have had an opportunity to meet the applicant and be a part of the process," she says. "This employee engagement is very valuable."

Staff have final say

Brian Sauders, manager of patient access services at Indiana University Health North Hospital in Carmel and Indiana University Health Saxony Hospital in Fishers, asks frontline staff to interview candidates, but only after patient access leadership has already determined that the individual is an acceptable hire.

"It allows the team to have a voice in the process," Sauders says. "They can pick up on attitudes and behaviors that may have been missed during the initial interview."

If the team recommends someone and leaders subsequently decide against their choice, that can have detrimental effects to their relationship, Sauders explains. "It's very important to be readily willing to extend an offer to any applicants interviewed by the frontline," he says. "We allow them to have the final decision."

Once applicants are hired, they know from the start that their colleagues really wanted them there, "which instantly begins to grow that team relationship," adds Sauders. *(See related story, below, on an applicant's customer service skills.)*

SOURCES

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Top skill you should look for? Service

Just because someone has ample experience with your specific admission/discharge/transfer system, that experience doesn't necessarily make them a good fit for a patient access position in your department, warns **Brian Sauders**, manager of patient access services at Indiana University Health North Hospital in Carmel and Indiana University Health Saxony Hospital in Fishers.

"The no. 1 priority should be whether the applicant demonstrates, has demonstrated in previous roles, or shows the ability to demonstrate high-quality customer service," he says.

To determine this ability, Sauders asks applicants behavioral-based questions, such as, "Please describe your most memorable experience trying to work

with an individual or group you didn't mesh with." "The key is that we are looking for an actual, specific encounter from their past," he says. "If the applicant's answer is more hypothetical, we redirect them to a real situation they have had in the past."

Sauders listens for red flags in the applicant's answers that indicate he or she doesn't possess good customer service skills. "These include signs that the applicant is reluctant to change, avoids teamwork, has difficulty prioritizing tasks, or is unwilling to help others," he says. ■

Can patients obtain price quotes on website?

Although 9,700 transactions were paid online by patients, totaling over $2 million in a nine-month period in 2011 and 2012 on San Diego-based Sharp HealthCare's website, those same patients can't yet obtain price quotes for services electronically.

"We have yet to refine a price estimator tool on the web," says **Maria Jimenez,** director of patient access. "I am not aware of any hospitals that currently offer this."

The biggest obstacle in offering online quotes is that the price is reflective of only the information provided by the patient or the patient's physician, Jimenez explains. "There is a possibility that the surgical procedure or planned service extends beyond the initial quoted price, due to unforeseen circumstances," she says.

Patients call hotline

Sharp Metropolitan Medical Campus has set up a "self-pay hotline" for patients to call and leave specific pieces of information so that a patient access representative can provide a verbal and written estimate.

"Most patients that access this hotline do not have insurance to cover their immediate healthcare need," Jimenez says. Patients are asked to leave as much information as possible on their healthcare needs, including the physician's name and phone number and the procedure's CPT code if available.

An access service representative then contacts the provider office to validate information given by the patient and generates a written estimate. "We have found that having a physician contact assists with providing patients with the most accurate cost estimate," says Jimenez. The patient's medical history and existing co-morbidities is valuable information to have, particularly for a self-pay quote for an inpatient procedure, she adds.

"It's important to know if a patient has pre-existing medical conditions," says Jimenez. "Our self-pay pricing methodology is based on Medicare DRG as a baseline. A DRG with complications and comorbidities, versus one without, may vary significantly in costs." *(See related story, below, on information needed for price quotes.)*

EXECUTIVE SUMMARY

Giving price quotes to patients online isn't a viable option for patient access departments due to the complexities of coverage, but increasing numbers of patients are calling to ask for this information.

- Set up a telephone hotline for price quotes.
- Obtain clinical information from the physician.
- Identify pre-existing medical conditions.

SOURCES

For more information on giving price quotes to patients, contact:
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Give a spot-on quote: It requires research

A prospective patient at St. Anthony's Medical Center in St. Louis, MO, can request a price quote be worked up by filling out a simple form on the hospital's website.

"But no one is using it," reports **Kathy L. Hughes**, FHFMA, director of patient accounts and admitting. "Instead, they just pick up the phone."

If a patient completed the online form, he or she would be called back by a financial counselor, who would then work up a price quote, but patients choose to call directly instead.

"The website also gives them the phone numbers to call, should they just want to speak with someone about the cost of a procedure," says Hughes. "We don't offer the ability to look up the price online."

The reason? There are so many variables involved, such as knowing the exact kind of test being performed, what kind of insurance the patient has, whether the patient has met their deductible for the year, and the contract price in place with the insurance company, she explains. "The reason that we do not just offer a look-up service that the patient can access

is the potential for them to see a charge and be turned off," says Hughes. "We would offer it if we felt that patients had enough knowledge to use it correctly. The technology exists."

Patients might not understand that what they will owe is impacted by their insurance plan and their benefit structure, for example. "The insurance benefits and contracts and types of plans are so complicated that sometimes the experts don't even understand it," says Hughes. "We sometimes have to call the doctor's office to get more information."

Specifics matter

To provide a price quote, the financial counselor needs the exact name of the test that the doctor has ordered or, preferably, the CPT-4 code, says Hughes.

There would be a difference in the price quote, for example, if the patients said they were having a CT scan with contrast and it turned out to be a CT scan with and without contrast, or if the patient said they had Medicare, but it turned out to be a Medicare HMO plan.

"Patients get frustrated when we ask for all of this information, because they don't understand all that goes into it," says Hughes. "We explain that we want to give them a good estimate." ■

Patients might owe more at your facility

Benefits may differ according to site

Even if a payer considers your hospital to be "in network," it might cost a patient more to obtain a service at your facility due to varying tiers of benefits for various facilities.

"This is a new twist that people may not be aware of," says **Brad Davenport**, director of the patient access center at The University of Tennessee Medical Center in Knoxville. "The patient may be in network but may have reduced benefits if they come to our facility."

Even though it's the payer's requirement, patient access staff are the ones who have to explain it to the patient standing in front of them, says Davenport. "We feel like it's our responsibility to make patients aware of it," he says. "Very few patients realize this. It's much worse for them to find it out on the back end."

Staff members tell the patient the additional amount they'll owe if they have the service at the facility and let them make the decision. "Some patients may say, 'I'm so glad you told me that,' or they may say, 'I'm coming there anyway,'" he says. "It depends on how badly they want to go to the facility."

EXECUTIVE SUMMARY

A patient's benefits might vary depending on the facility where a service is obtained, even if the hospital is in network.

- Tell patients the additional amount they'll owe.
- Inform patients if services might not be covered.
- Resolve problems before scheduled date of service.

Confusion results

Davenport says that his staff members often are in the position of telling patients that Medicare might not cover the services, because Medicare might determine the service is not medically necessary or a covered procedure.

"We are dealing with that pretty regularly," he says. "We try to resolve it beforehand. But if the patient is here, all we can tell the patient is that it may or may not be covered."

This situation is confusing to patients because they don't understand why a service their physician thinks they need to have might not be covered, he adds.

Staff members work hard to educate patients about their coverage and plan requirements, Davenport says. "We tell them all hospitals are under these same regulations and we are providing the information so they can make an informed decision," he says.

Staff tell patients, "It appears this service may not be covered by Medicare, as it may not meet their medical necessity requirements. You can still have this service, and we will bill Medicare. But if they do not cover this, you may be responsible for the charge."

Timing is key

"More tests are requiring certification. The sooner we can determine whether we have financial clearance, the more time we have to resolve the issues," says Davenport.

"Timing is everything" to avoid problems with services being denied, he says. A provider initially might order an magnetic resonance imaging scan, but the payer might require that an X-ray or CT scan be performed instead. "They may deny an inpatient admission and require a service to start as outpatient," he adds.

Staff members make every attempt to resolve these coverage issues before the scheduled date of service. "If we determine this ahead of time, the patient can decide if they are still going to have the service," Davenport says. "Or they can contact their physician about the plan of care."

SOURCE

For more information on educating patients on their coverage, contact:
• **Brad Davenport**, Director, Patient Access Center, The University of Tennessee Medical Center, Knoxville. Phone: (865) 305-9018. Email: BDavenpo@mc.utmck.edu. ■

Save 30 minutes by notifying online

At times, registrars are stuck on the phone for 30 minutes before even speaking to a representative, when notifying a payer of a patient's admission, says **Amy Lloyd**, patient access coordinator at Trinity Muscatine (IA).

Being able to submit notifications to payers electronically is "a huge timesaver," says Lloyd. "The traditional call to the insurance company could take a while, especially during peak hours."

Staff can notify payers at any time of day, even during after-hours or weekends/holidays if needed, she adds.

Electronic notification has dramatically cut the amount of time staff spend being placed on hold with payers, says **Natalie Uy**, RN, BSN, CCM, manager of patient access and emergency department registration at WakeMed Health and Hospitals in Raleigh, NC. "Because we are no longer spending time on hold or being transferred from one department to another, we were able to handle an increase in patients without a substantial increase in staff," she reports.

Denials still possible

While online notification means less time on the phone with payers, staff still need to follow up to be sure there were no system errors, advises **Sandra N. Rivera**, RN, BSN, CHAM, director of patient access at St. Joseph's Regional Medical Center and St. Joseph's Wayne Hospital, both in Paterson, NJ.

"Payers need to get on board to develop a standard way of doing this that is efficient," Rivera adds. "Currently, we do something different for every payer, including using different software."

Data errors could cause a delay in notification that could result in a claims denial, she says. For one payer, staff members manually enter the data and later view the authorization, which then has to be transcribed into the billing system.

Staff members scan the screen print of the authorization into the patient's account, so the billing staff can easily access it if necessary, says Lloyd. At least half of the department's notifications are now done online, she says, which takes about 5 minutes, depending on whether the data elements needed are available to the access staff at the time of entry. For example, payers might require clinical documentation to be attached.

"Some sites require diagnosis codes, which our access staff do not have

available. Those are left for the next business day," says Lloyd.

Electronic notifications are frequently time-stamped as to the time the notification to the payer was completed, says Uy, which gives proof of the exact date and time it was done. "When claims are unjustly denied or reimbursement penalties are applied, we are able to appeal these," she says. *(See related story, below, on the department's process for obtaining authorizations.)*

SOURCES

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• **Sandra N. Rivera**, RN, BSN, CHAM, Director, Patient Access, St. Joseph's Wayne Hospital and St. Joseph's Regional Medical Center, Paterson, NJ. Phone: (973) 754-2206. Fax: (973) 754-4662. E-mail: riveras@sjhmc.org.
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EXECUTIVE SUMMARY

More payers are allowing electronic notification of admissions, which can prevent time-consuming phone calls. To avoid claims denials:
• Follow up to be sure there weren't system errors.
• Scan the authorization into the patient's account.
• Use time-stamped entries to appeal denials.

Denials cut with this process

Previously, 10 to 20 claims were denied each month at WakeMedHealth and Hospitals in Raleigh, NC because of failure to notify the payer.

"Now, we have less than five denials per month related to notification," reports **Natalie Uy**, RN, BSN, CCM, manager of patient access and emergency department registration. "Most of these denials are due to late discovery of insurance or unjustified penalties." Here is the process used by patient access staff:

For urgent/emergent admissions that present to the

hospital through the emergency department, direct admission from the physician office, from home, or transferred from other hospitals:

1. The insurance verification team, which is part of patient access, verifies the insurance coverage and eligibility.
2. The team notifies the insurance company of the admission electronically, via fax, or by telephone.
3. If clinical information is required, the team notifies case management. "If the insurance company has not assigned a case manager to the case, we provide the insurance company the contact number for our case management department, which provides the needed clinical information," says Uy.

For scheduled cases:

1. Physician offices contact the third party payers to initiate the prior authorization process.
2. The insurance verification team verifies the insurance eligibility and coverage, the presence of the authorization, and the team confirms that it matches the procedure/service.
3. The team contacts the physician office if a required authorization has not been initiated.

"If case is not authorized, and the physician office is still working the case and does not want to postpone the case, or if the patient insists on having the service, we have the patient sign an advance beneficiary notice," says Uy.

4. The team notifies the insurance company on the day of admission, if this information is required by the payer. ■

Be involved before switch to new ADT system

Before a new admission/discharge/transfer (ADT) system was implemented at Lee Memorial Health System in Fort Myers, FL, three patient access leaders were pulled from their previous jobs and worked full-time on the system implementation.

This group included **Colleen Edwards**, system director of registration and patient business services. "We need to be sitting at the table from the very beginning," she emphasizes. "Patient access can offer a tremendous amount of valuable information on patient flow and delays."

Before the new system was implemented, Edwards and other patient access leaders took these steps:

• They pointed out areas where steps could be taken out of the process.

While clinicians make the decision to change a patient's status from outpatient to inpatient, it was registrars who entered the information into the system, says Edwards.

"Changing the statuses of patients was always part of our function," she says. "We would get a call or report stating the status needed to change, and we would make the necessary change."

Patient access leaders pointed out that a step could be saved by giving case managers the ability to make the change to eliminate the step of calling someone else to tell them to do it, says Edwards.

• They cleared up misunderstandings about the role of patient access.

"Clinicians often don't understand what access is about. It can seem easy from a distance, but if you don't do it, you don't have any idea what it takes to get it done," Edwards says.

Identifying the correct patient is not always easy, she says. "With hyphenated names, name changes, and patients without social security numbers, just making the right selection can be a challenge," Edwards says. "And identifying the correct payer, with all the HMOs, PPOs, and networks, is a difficult task."

Patient access leaders took the opportunity to educate clinicians on all the information that registrars are required to give to patients and what it takes to accurately identify a patient, she says.

• They examined every patient access process.

An in-depth workflow was even performed on the process of scanning documents to ensure they can be easily found later, she says. "We learned that although it sounds good to be able to scan each document to its own document type versus document group, it is more time-consuming doing it this way," says Edwards. "And in the ED, every second counts."

• They considered the effect on revenue.

"We are responsible to ensure we can be paid for the

EXECUTIVE SUMMARY

Patient access must be involved with an admission/discharge/transfer (ADT) system implementation from the beginning to provide input on patient flow and delays.
- Have clinical areas change the patient's status in the system.
- Educate others on the role of patient access.
- Identify ways to cut delays in scanning documents.

COMING IN FUTURE MONTHS

- ■ Dramatically cut training costs with e-learning
- ■ What to do if payers give inaccurate information
- ■ Revamp your admission notification processes
- ■ Proven strategies for communication with clinicians

services we are providing by identifying any available funding source," says Edwards. "That is one of our roles in the organization."

By looking at the entire process before the implementation, says Edwards, "people realized very quickly how much detail is involved just to get one bill paid." *(See related story on avoiding problems on the "go live" day, below.)*

SOURCE

For more information on patient access and system implementations, contact:

• **Colleen Edwards**, System Director, Registration and Patient Business Services/ADT Project Team Member, Lee Memorial Health System, Fort Myers, FL. Phone: (239) 424-3297. Email: colleen.edwards@leememorial.org. ■

Make 'go live' go smoothly

On the morning a new admission/discharge/transfer (ADT) system was going live at one of Fort Myers, FL-based Lee Memorial Health System's hospitals, **Colleen Edwards**, system director of registration and patient business services, had "a huge fear we would have lines of people, going all the way out the door. But that's not what happened."

Edwards credits the minimal delays to the fact that patient access leaders were closely involved in the entire process before the hospital's fully integrated system was implemented. Here is how they made the "go-live" day go smoothly:

• A large number of trained staff members were onsite.

This step was to ensure everyone had "elbow support," as staff registered patients for the first time using the new system, says Edwards.

• Signs were posted.

"These told people what to expect and asked them to please be patient with us," Edwards says.

• Staff members were required to practice three to five hours a week.

"We involved staff in the backload of scheduled patients which provided them more practice time," Edwards says.

Speed and accuracy has greatly improved in registration areas due to the newly implemented system, she reports. "Before, we randomly picked accounts and review certain fields and notes. Now, we can run reports by user," Edwards says. "We can drill right down to exactly what errors are occurring, how often, and by whom." ■