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It's time for patient access to obtain parity with business office

Outdated compensation model is costly

[Editor's Note: On 6/24/13, we sent an e-bulletin to Hospital Access Management *subscribers on a report concluding that organizations need new revenue cycle tools. If you didn't receive it, it means we don't have your email address. You can receive future bulletins by contacting customer service at customerservice@ahcmedia.com or (800) 688-2421.]*

Salaries of patient access employees are too low in light of their greatly expanded role, and there are serious consequences if this under-compensation isn't corrected, argue revenue cycle experts interviewed by *Hospital Access Management*.

"Access has become very vital, but the perception in the industry hasn't changed to accept that yet," says **Michael Hester**, vice president of the revenue cycle in the finance department at Nationwide Children's Hospital in Columbus, OH. "There are still too many people who think access is just a meet-and-greet position."

Hester estimates that at least a 30% to 40% increase in compensation is needed for patient access employees in his department. "Patient access salaries need to be brought not just in line with the business office, but above the business office," Hester emphasizes. "My goal is that the front end will be a higher level than the back end."

EXECUTIVE SUMMARY

Patient access employees are under-compensated at many organizations, and salaries don't reflect the expanded role of patient access, according to revenue cycle experts. Present an analysis of these factors to administrators:
- the cost of failing to obtain correct information on the front end;
- the amount collected on the front end, compared to previous years;
- savings resulting from reduced back end staffing.

AHC Media

Patient access leaders must make sure hospital administrators never forget the key role access plays in the hospital's financial well-being, says **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle management at Emory Hospitals in Atlanta. Short-changing patient access staff limits the organization's ability to retain and attract competent staff with the right qualifications, argues Kraus. "Just as a poorly paid business office is likely to be deficient in billing and collections, performance issues are likely to impact poorly paid, understaffed access departments," he says.

The biggest selling point for patient access leaders seeking to attain parity with the business office, or perhaps even pulling ahead of those salaries, is the shift in collections responsibility to the front end, says Kraus. This includes both point-of-service collections and accurate completion of patient financial records prior to billing to produce a clean claim.

"To do this well involves a level of staff training and expertise at least the equal of business office billing and collections staff," he explains. *(See related story on business office and patient access job descriptions, p. 100.)*

Who they're putting in the front end

More than half of revenue cycle executives are now staffing the front end with their strongest revenue cycle employees, according to a recent survey.[1] **Steven S. Lazarus**, PhD, president of Boundary Information Group, the Denver healthcare consulting firm that conducted the survey, says, "Some of the skill sets that are being moved to the patient access departments have historically been performed in the business office collections operations." Examples include financial discussions during appointment scheduling, pre-registration, and collection of more detailed demographic information.

The migration of financial counseling from the back end to the front end prevents unpleasant surprises with billing and collections because it puts a patient's finances in order prior to date of service, says Kraus. "The increase in responsibility and accountability applies across the range from entry-level staff to director," he adds.

Perform your own analysis

The outdated compensation model for patient access is clearly failing, argues Hester. "That's why we need to create a new model, with patient access no longer perceived as an entry-level position," he says. "There is a need to basically create an entire new job code within the industry, with a new salary range specific to that." *(See related stories on comparing patient access salaries with outside industries, p. 99.)*

To demonstrate the return on investment that will come from increasing patient access salaries, Hester says to take these steps:

1. Increase the requirements for patient access roles.

Currently, most job descriptions for patient access focus primarily on entry-level customer

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service skills. "These are still critical, but inadequate in our current environment," says Hester. "The position is a dynamic, multi-faceted role that changes from day to day." Computer skills, independent thinking, a college degree, interpersonal skills, and conflict resolution skills are just some of the necessary requirements, he says.

"We need to market the value of the patient access rep," says Hester. "Make it more of a career path, instead of a 'Get your foot in the door until you find another job' type of position."

He says lack of qualified staff results in too much turnover, which is something that was financially acceptable when patient access was an entry-level position, but no longer. "If we can reduce turnover by just a couple of percentage points, that has a wide effect not just on the cost of recruiting, but also HR, and overtime to fill that vacant position while we are waiting for somebody to take it," Hester says.

2. Evaluate the potential cost of failing to getting the information correct on the front end.

"Denials will be reduced, and can be quantified," he adds. "Even taking a conservative approach of anticipating a reduction of bad debt by 20% and denials by 40% will still produce an ROI [return on investment] for increasing front-end salary ranges."

3. Evaluate the dollars collected on the front end, compared to historical trends.

"For every dollar we collect on the front end, we have just reduced our bad debt by 50 to 60 cents," says Hester.

4. Calculate dollars that can be saved by reducing back end staffing.

"Through the improvements on the front end, you should see a reduction of necessity on the back end," says Hester. "It is a reallocation of resources."

After patient access salaries are increased, FTEs on the back end can be reduced over the next 12 to 18 months, he says. If the front end is doing their job correctly, the back end's responsibilities should be relegated to verifying that payments were posted correctly, explains Hester.

"Nowadays, it's much more clear-cut that if you bill appropriately, you get paid appropriately," he says. "You don't need as high a technical skill on the back end as you did previously."

5. Present your analysis to senior leaders.

"Show them the positive return on investment, after you have put all those details together," says Hester. "Once they put the resources into patient access, everything else will fall in place."

REFERENCE

1. Boundary Information Group. The impact of growing patient financial responsibility on healthcare providers. June 2013; Denver. Available at www.boundary.net.

SOURCES

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Compare salaries to outside industries

Look for jobs with similar skill sets

If you compare patient access salaries at your organization with those at other hospitals, the job expectations will be similar, but salary ranges are likely to be outdated.

"They are still going to be based on what the perception of patient access was, versus what it is today," says **Michael Hester**, vice president of revenue cycle in the finance department at Nationwide Children's Hospital in Columbus, OH.

Hester recommends a different approach. "You need to take different pieces of the patient access role —- the financial counseling component, the clinical aspect — and look at outside industries," he says. "Don't look at the title. Look at the skill set behind it." Here are some examples:

- the insurance industry, where employees handle eligibility and authorizations;
- the hospitality industry, where employees are expected to provide a high level of customer service;
- the collection industry, where salaries are typically low, but compensation includes commissions based on how much is collected;
- the coding industry, which reflects a skill set now required of patient access.

"Compare salary ranges," says Hester. "Determine where you are in the market range and what the cost to the organization would be to change patient access salaries." ■

First step: Update job descriptions!

Show what staff actually do

Today's patient access employees are expected to interpret insurance identification cards, verify benefits, use various computer systems, perform real-time eligibility, obtain authorizations, and collect from patients, but salaries typically don't reflect any of these complex skills.

The first step toward increasing compensation for patient access is to rewrite job descriptions to reflect what employees actually are doing, says **Michael Hester**, vice president of revenue cycle in the finance department at Nationwide Children's Hospital in Columbus, OH. For example, the department soon will implement a price estimation tool that will change what employees are expected to do.

"This will put substantially more pressure on the patient access reps to ask for money from the patient, explain their insurance benefits, and why we expect copays and deductibles prior to services being rendered," says Hester.

Skill sets vary

Job descriptions don't always reflect the different skill sets involved in various patient access roles, which vary widely.

"You must consider the fact that patient access representatives have different skill sets, depending on what they do in the organization," says Hester.

Hester is rewriting patient access job descriptions at his organization. "Unfortunately, we currently have one generic job description that encompasses multiple positions throughout the organization," he says.

Patient access job descriptions should be updated at least annually, says Hester. "With technology and changes in the industry coming so quickly, the expectations are moving literally on a daily basis," he says. ■

Same job descriptions for front & back end

Salaries made equal

Several years ago, job descriptions for staff in patient access and the business office were made the same at Emory Hospitals in Atlanta.

"It equalized salaries and provided a career path," reports **Pete Kraus**, CHAM, CPAR, FHAM, business analyst for revenue cycle management. Staff members are designated as patient accounts representatives I, II and III, and they can move up to coordinator, supervisor, manager, assistant director, and director.

"This approach hasn't resulted in staff moving seamlessly between the front and back ends," notes Kraus. "As jobs open up, staff can apply internally. Some cross over, but most stay on the side they were hired to."

Different skill sets

Matching job descriptions raised the question of whether patient access and the business office really needed to be separate, or whether these areas could be merged.

"Is it possible to develop a departmental model that does away with the distinction between the front end and back end entirely — and the internal staff animosity that it has engendered over at least the last 40 or 50 years?" asks Kraus.

Kraus points to several obstacles. "The front end and back end are pretty easily defined, and it is a traditional, deeply engrained concept," he says.

In addition, there are differing skill sets that attract certain people to one side or the other. "Even so, in the context of current revenue cycle operations and management, the time may be upon us to jettison the notion of separate staff to handle pre and post-encounter patient financial activity," he says.

Some individuals who make great business office employees aren't particularly adept at the people skills required for top-notch performance in patient access. Likewise, some potential members of the patient access staff members possess excellent people skills but don't have an affinity for the business side.

"These folks, bless their hearts, are no longer who access should be hiring," says Kraus. "Access needs staff who have it all, hence the justification for higher salaries."

Compare qualifications

Among the leading healthcare providers, patient access is well on its way to parity with business office staff, and in some cases, is already there, according to Kraus.

"If facilities experience a lag between increasing job expectations and salary adjustment, budgetary constraints are likely to be the most commonly cited reason," he says.

Kraus says to compare job qualifications for the

business office with those of patient access staff. Then, compare patient access staff qualifications with real-life expectations of the job.

Finally, ask the question, "If expectations were lowered to match the current patient access job descriptions, what would be the consequences for business office and the bottom line?"

"Although it might be an ambitious and audacious undertaking, an access director could probably review such data and provide a compelling analysis," says Kraus. ■

$2.6 more revenue captured with audits

Denials cut to only .08%

Patient access leaders at Florida Hospital in Orlando don't spend much time auditing denied claims, because there simply aren't many of them. The department has a current denial rate of just .08%.

"We began this process in 2002. In that year, we wrote off $4.5 million or .42%," says **Bonnie Hache**, administrative director of patient access. "If we were still at that rate, we would have written off almost $10 million in 2012."

In 2012, the hospital wrote off $1.9 million. "The Healthcare Advisory Board reports hospitals run at an average of .8%. That would represent $18 million for Florida Hospital," says Hache.

Hache credits her department's success to being "very intentional in reviewing why mistakes are made and training our staff. If you don't take the time to do that, you will not improve." The department's "denial avoidance process" includes weekly meetings at which every denial of more than $1,000 is reviewed in detail. "Then, we meet with reps on an individual level so they can figure out what they did wrong," she says.

EXECUTIVE SUMMARY

Patient access leaders at Florida Hospital cut denials to only .08%, and wrote off $1.9 million in 2012 compared with $4.5 million in 2002. The department credits its success to these steps:

- Every denial of more than $1,000 is reviewed in detail.
- Managers meet with representatives one-on-one to review denied claims.
- Clinical areas are closely involved in avoiding denials.

Staff members stay on top of all changes, such as a recent trend toward payers requiring more clinical information to meet requirements for medical necessity. Many times, an authorization is no longer enough. Payers want to review all the physician's records on the patient to ensure all steps have been taken to avoid a high-cost test.

"Insurance companies are looking much closer at every service we provide and hold us to a much higher standard for obtaining authorizations," says Hache.

Involve clinical areas

Florida Hospital's patient access management and other members of the denial avoidance team routinely round in clinical areas to discuss issues causing denials.

"We are leaders in this area, but it is only by working together," says Hache. "We make sure we are meeting their needs, and we listen to what they say."

Clinical areas openly discuss the challenges they are facing working with physicians, for example. "Their assistance in speaking with physicians regarding services that are not covered is instrumental in making changes," says Hache. Recently, Hache made clinical areas aware of these reasons for denied claims:

- Some payers require a CT scan to be done before a positron emission tomography (PET) scan will be authorized.
- Some payers require documentation of alternative approaches before authorizing physical therapy, such as taking anti-inflammatories for a specific amount of time.

"We take account-level information back to them," she says. "We share with them what was missed, and discuss what they can provide to us in the future."

Process is manual

Hache doesn't think investment in technology to audit denials would be cost-effective at this point in time, since denials are so few.

The manual process used by the department was very labor-intensive at first, but it is much more manageable due to the low error rate, she reports. "We have no plans to automate this process," she says. "Our denials are so low that to spend a lot of money on technology doesn't make sense," she says.

Last year, "no auth" denials totaled just $250,000. Most of these occurred because of mistakes made by patient access representatives, such as taking the provider's office's word that no authorization was required instead of calling the payer directly.

"Those are mistakes that even technology couldn't help us with. Some human error will occur," she says.

SOURCE

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POS collections up 53% after changes

Collections increased by 53% from Fiscal Year 2011 to 2013 at University of Pittsburgh Medical Center (UPMC) after patient access departments implemented an action plan focusing on the emergency department (ED) and imaging services.

"In order to be successful, we had to engage our front-line staff with our vision of sustaining collections and looking for solutions for the long term," says **Georgina Trunzo,** executive director of patient access services for UPMC's Hospital Division. These steps were taken:

1. Managers taught staff to use payer eligibility technology.

"Knowing what to collect was critical," Trunzo says. "We continually provide front-line staff with the most current and accurate patient copay information."

At check in, the system provides the front-desk staff with the copay amount that is due from the patient, based on the insurance benefit plan on the patient's account. "This facilitates upfront collection by providing staff with the information they need in real-time," says Trunzo.

2. Staff members were taught how to ask patients for money.

Front-desk staff members complete a required training curriculum that includes how to ask for payment, as well as posting of any and all patient liabilities.

Patient access leaders developed online training for collection of co-pays, and the organization's system was changed so that outstanding patient balances are visible to front-desk staff at the point of payment posting. "This provides an additional opportunity to ask for payment while the patient is present," says Trunzo.

3. Goals were established for point-of-service (POS) collections, with daily, weekly and monthly reporting to track progress.

"Accountability was key," Trunzo says. "Point-of-service collection information is electronically published, with trending of results by business unit."

On a monthly basis, cash collection reports are published electronically and include amounts due and collected, along with collection percentages. "This allows operations managers to monitor upfront collections specific to their worksite and to published benchmarks and expectations," says Trunzo.

4. Patient access leaders worked with imaging and ED advisory leadership across the UPMC system.

"Each facility patient access director has open dialogue with their clinical colleagues," she says. "On a regular basis, we share top collectors, attainment of goals, or areas to improve."

In the ED, clinical colleagues also are engaged with directing patients to the discharge window by giving patients discharge instructions and asking them to stop at registration.

Two EDs are piloting handheld devices that allow staff to collect directly at the bedside. "This has improved patient satisfaction in that it eliminates a stop at a discharge window," she says. "Patients like to have someone take their credit card real time in front of them and not have additional worries about information being compromised."

Patient access leaders worked with clinical colleagues in imaging services in these ways:

- Patients are informed at the point of scheduling that if a copay is due, it will be collected at the time of service.
- Patients are given the choice to pay online from their home or at the point of service.
- Patients are reminded of their copay obligations as part of automated appointment reminder calls.

"We also collect both physician and facility copays at our front desks for our hospital-based clinics, as well as at those physician sites that have imbedded ancillary services," she says.

Patient access provided clinical areas with scripting and educational materials utilized by access personnel to increase their awareness level of patient liability and collection.

"This will become even more critical in the very near future, with more patients having out-of-pocket liability," says Trunzo.

EXECUTIVE SUMMARY

University of Pittsburgh Medical Center increased collections by 53% after an action plan was implemented, focusing on the emergency department and imaging services.

- Patient access leaders developed online training for collection of co-pays.
- Outstanding patient balances are visible to front-desk staff at the point of payment posting.
- Clinical colleagues inform patients at the point of scheduling that copays will be collected at the point of service (POS).

SOURCE

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Must-have technology for healthcare reform

Outdated tools equal lost revenue

There is no question that patient access departments must use available technology to prepare for the implementation of the Affordable Care Act. But what technology is going to be most important for patient access?

Hospital Access Management asked industry experts this compelling question. Here are their answers:

• Technology that allows staff to provide accurate and reliable patient liability estimates.

"Being transparent with the patients upfront regarding their estimated liabilities will improve patient satisfaction," says **Marie-Louise Stanek**, a consultant with Accenture Health Practice in Atlanta.

Staff members need to use price estimation tools based on clinical order information provided during scheduling, which allows them to estimate liability and alert pre-registration to collection opportunities prior to patient arrival, says **Paul Shorrosh**, founder and CEO of AccuReg Patient Access Solutions. "Then, if dollars estimated are not collected by point of service, communicate and escalate the situation at every hand-off point," advises Shorrosh. "We all know that a dollar collected pre-service is worth more than a dollar collected post-service."

The goal is for every staff member to be used as a patient reminder and opportunity to collect the balance estimated prior to service, he says.

EXECUTIVE SUMMARY

Patient access departments need technology to determine patient liability, propensity to pay, and eligibility to enroll in health plans available on the exchanges. Revenue cycle experts say to expect these changes from healthcare reform:

- More patients will choose high-deductible health plans.
- Patients will need to be screened for a variety of possible financial sources.
- Out-of-pocket expenses will increase.

• Eligibility verification tools, to identify patients who are eligible to enroll in health plans available on the exchanges.

Insurance eligibility software is needed not only to verify insurance eligibility, but also to determine patient liability amounts before, or at, the time of service, emphasizes **Patrick Teta**, a senior consultant with Revenue Cycle Solutions in Pittsburgh. The reason is that the projected increases in insurance premiums will likely lead to more patients selecting high-deductible health plans to cut costs.

"It will be vital for patient access staff to have accurate, up-to-date, patient responsibility information to address these amounts," says Teta. "Also, the projected increase in Medicaid enrollees will make it vital to check Medicaid eligibility on self-pay patients."

• E-Cashiering.

Web-based patient portals enable efficient online payments and are familiar to consumers, says June Yee Felix, managing director of Global Healthcare at Citi Enterprise Payments.

"They also simplify and reduce the effort and costs involved in accepting higher volumes and higher dollar values of patient payments," says Felix.

Increased adoption of some payment portal offerings might even help providers qualify for Meaningful Use credits, depending on the specific portal capabilities and deployment model. "These provide significant return in terms of increased patient collections, reduced billing costs, and an improved patient experience," says Felix.

• Propensity-to-pay software.

"Participants in the new health insurance marketplaces who choose the least comprehensive and cheapest plans will have much higher deductibles and copays than typical employer-based coverage," says **Ken Perez**, senior vice president of marketing and director of healthcare policy at MedeAnalytics. "Thus, patient access departments need to increase pre-service cash collections."

Due to higher out-of-pocket expenses, collecting also includes staff evaluation of a patient's propensity to pay, and screening patients for a variety of possible financial sources such as Medicaid, payment plans, loan programs, or charity care. Shorrosh says, "The more automated and simple these processes can be, the better patient access staff will be able to perform them. It will require a new generation of patient access technology to empower them to do more with less." *(See related stories on inadequate use of technology, p. 104, and integration of tools used by patient access, p. 104.)*

Perez says hospitals are increasingly concerned about higher uncompensated care costs resulting from patients not paying high deductibles and copays.

"Predictive modeling techniques to appropriately segment patients prior to service, in order to prompt registrars to take appropriate action, are critical," says Perez. ■

Inadequate use of technology?

Expect decrease in cash flow

Many patient access departments still aren't doing any eligibility checking at all, according to **Patrick Teta**, a senior consultant with Revenue Cycle Solutions in Pittsburgh.

"Propensity to pay, ecashiering, and registration kiosks are mainly done at larger facilities," he adds. "Hospitals that aren't up-to-date will face rework downstream in the revenue cycle."

Most patient access departments, including pre-service and centralized scheduling units, lack the appropriate technology needed to be more efficient and to work smarter, thus eliminating the need for many manual and duplicative processes, says **Marie-Louise Stanek**, a consultant with Accenture Health Practice in Atlanta. "Hospitals often dedicate technology funding to those systems that are related directly to patient care, especially with meaningful use standards," she says. "This appears to be a common theme within healthcare systems, as well as smaller community hospitals."

Much of the focus regarding healthcare reform targets payment issues and the anticipated increase in out-of-pocket expenses, including higher deductibles and coinsurance, adds Stanek.

"Patient access departments that do not have the appropriate technology in place could experience a decrease in cash flow, as well as an increase in bad debt," she warns. ■

Patient access tools aren't always integrated

Department's success depends on it

In a busy patient access area, it is vital that tools are integrated into the hospital's information system, says **Patrick Teta**, a senior consultant with Revenue Cycle Solutions in Pittsburgh.

"Bolt-on" solutions can slow the registration process, negatively impacting patient satisfaction. "Any time you have to take your hands off the keyboard, or refocus your attention on an application outside of your registration system, it is going to add to the patient registration time," explains Teta.

Hospital information system companies have been slow to truly integrate bolt-on applications, says Teta, but some information systems have integrated insurance eligibility, charge estimation, cash drawer handling, and medical necessity into their registration screens. In some cases, patient access departments have Internet-based bolt-on systems to check eligibility, medical necessity, or propensity to pay, but employees don't use them because the connections are too slow, says Teta.

"Even if using a bolt-on product only adds one minute to a four-minute registration, you've increased your wait time and decreased your productivity," he says.

Tools working together

Patient access needs a suite of technology products working in concert with one another that match with every distinct patient access process that must be completed prior to service, according to **Paul Shorrosh**, founder and CEO of AccuReg Patient Access Solutions in Mobile, AL.

"Registrars don't need another eight tools. They need one tool that will do eight things automatically, with exception-based workflows, and performance management to ensure resolutions prior to service delivery," says Shorrosh.

There is no "silver bullet" to buy, he says. Instead, patient access leaders need integrated tools that allow employees to be successful in an increasingly complex work situation, Shorrosh says.

Estimation and eligibility verification are two obvious needs, but patient access can't stop there, he says. Address and identity verification, prior authorization management, medical necessity screening, and financial screening all need to be considered. "Reform will bring even more complexity and urgency to screening and verifying patients. There are multiple layers of payment risks to the facility, not just collecting liabilities," says Shorrosh.

Shorrosh says the best systems automate multiple business processes and distill the exceptions, warnings, errors, and opportunities into a simple individual work console for each registrar and pre-registrar.

"Timing is another success factor," he says. "The more we can do in scheduling and pre-registration, the better the entire healthcare system will work for patients and for providers." ■

Not all denials are the fault of access

Many wrongly attributed to front end

Recently, a payer denied an $18,000 claim as non-covered services at Ochsner Health System in New Orleans, but this denial was challenged by patient access leaders.

"When we reviewed the case, we were able to show where the procedure was covered by the plan and our authorization and benefit verification supported that this should have been covered," says **Stacy Calvaruso**, CHAM, assistant vice president of patient management.

When the department's denial team researched it further, they found out that the provider had not updated their roster with the plan. "The service was a covered service, and if we would have just accepted this, then we would have lost out on $18,000 in reimbursement," says Calvaruso.

This case is an example of how patient access often is blamed for claims denials that other areas are responsible for, she says. "Approximately 25% of claim denials are actually not related to an action that the registrar did or did not do," she estimates. "It is problematic because the department is perceived negatively."

The trick is to look at denial reports with a critical eye, Calvaruso emphasizes. "When you really break this apart and look for areas that were controllable versus non-controllable, you see that many of the errors that are classified as front-end errors are really not," she says.

ID root causes

Calvaruso says that patient access leaders should review accounts in great detail to look for the error that resulted in a denial.

"Dig into your denial reports to ensure that you understand the root cause of the denials," she says. For example, an invalid authorization denial could be perceived as patient access not properly obtaining an authorization. "In actuality, it could be that the procedure performed was changed," says Calvaruso. Another reason for the denial could be that the service requires a specific work-up that was not disclosed by the payer upon the initial request for insurance verification and eligibility determination.

"Be sure that when the batches are coded, they are coded with the correct code; therefore, it falls to the appropriate responsible party," adds Calvaruso.

She works with the department's denials team to identify, by American National Standards Institute (ANSI) reason code, those items that are not typically related to patient access. "We go through each ANSI reason code by major plan," Calvaruso says. "This is very time-consuming, but very necessary."

After an initial review, Calvaruso asked the hospital's cash posting team to alert patient access on any new ANSI codes they receive. "An ANSI code may have a meaning for Plan A which could be different than what Plan X has interpreted," she says.

For example, Medicare gives a denial using ANSI code 50 for lack of medical necessity, while Humana uses ANSI code 96 but gives an additional remark code of N115 for lack of medical necessity denials.

"We challenge the denials team members on how accounts were processed," says Calvaruso. "We ask that they not accept the actual ANSI code, and truly look into whether or not the ANSI code was applied appropriately by the plan."

SOURCE

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EXECUTIVE SUMMARY

Many denied claims are wrongly attributed to patient access, which leads to negative perceptions about the department. To address this issue:
• Carefully review accounts and look for the error that resulted in a denial.
• Identify which reason codes are not typically related to patient access.
• Be sure batches are coded correctly.

Prevent the problem of eligibility denial

A patient presents with an insurance card, the registrar verifies the benefits and receives an eligible response — yet the claim is still denied.

This situation can happen when a patient has been terminated with their employer, because former employees have several weeks to decide if they want to purchase COBRA coverage.

"Until that decision is made, this patient is con-

sidered insured, and the plan's roster reflects them as eligible," explains **Stacy Calvaruso**, CHAM, assistant vice president of patient management at Ochsner Health System in New Orleans.

The termination date is only put into the plan's system when the COBRA election period passes, or the patient declines COBRA benefits, she adds. Often, this situation leads to an eligibility denial. To address this problem, patient access employees perform a pre-bill batch eligibility run that reverifies the patients' eligibility. If the patient comes back as ineligible, staff members then attempt to contact the patient for their updated insurance. If staff members confirm the patient is self-pay, they move the account to a self-pay status.

"This is very helpful in forecasting reimbursement and keeps the A/R clean," says Calvaruso. ■

Give better answers to toughest questions

Patients need complex information on coverage

Every day, patient access staff at University of California — Los Angeles Health System receive many inquiries from patients or family members that do not understand how their insurance works — Medicare, Medicaid, and commercial insurances alike, reports insurance verification manager **Jose Angel Torres**.

"A large majority of patients do not understand their own benefits," he says. "The big question on everyone's mind is 'How much will I have to pay out of pocket?'"

Patients are confused about copays, deductibles, co-insurances, out-of-pocket maximums, calendar or lifetime maximums and how these apply to the type of visit, procedure, or hospitalization someone is having, says Torres. "One can empathize with a layperson trying to understand the complexities of our insurance system," he says. Here are changes made by the department to help patients with questions about their coverage:

• Entry-level registrars, who aren't as well-versed in insurance coverage, direct patients to the correct area for assistance.

Whenever in doubt, staff members are asked to defer to their supervisors or managers. "Whenever our management team is in doubt, we reach out to our billing office, our contracting office, or have a follow-up call to the patient's insurance company," says Torres.

• One office within the health system, which is Patient Financial Services, is designated as the go-to area for questions about insurance and benefits.

"Our physicians' offices also refer calls to this group to answer questions," says Torres. "Sometimes an inquiry might require follow up."

In this case, the financial counselor takes the patient's name and contact number and reaches out to the appropriate areas such as the insurance company, billing, or contracting, and the counselor finds the correct answer.

• When there are concerns or discrepancies, a three-way conversation with an insurance company representative is held.

A patient might not be aware of the correct insurance terminology, so it helps to have an access staff member act as a liaison. "For those patients that are more informed, we can refer them to their payers. But many patients will appreciate the extra assistance," says Torres.

At Gundersen Lutheran Health System in La Crosse, WI, patient access employees give patients a card called "Answering your Billing Questions." "It has our department telephone numbers to call when the patient has questions," says **Barb Ramsey**, manager of patient services.

Patients are directed to financial counselors when they aren't able to pay for their services that day, if they have questions about their bills, or if they need to change their coverage in order to come to the organization.

"We have financial counselors out on our floors, who are available to come directly to any department," says Ramsey.

EXECUTIVE SUMMARY

Patient access employees are fielding more questions from patients about their insurance coverage. These changes were made at the University of California — Los Angeles Health System:

- Follow-up calls are made to the payer if necessary.
- Patient Financial Services was designated as the go-to area.
- Financial counselors follow up with patients as needed.

SOURCES

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Why do doctors still have paper records?

(Editor's note: This piece is part of a reporting partnership among National Public Radio, Colorado Public Radio, and Kaiser Health News.)

Uncle Sam wants your doctors to go digital. And the federal government is backing up that goal by offering money to practices if they start using digital records systems. Nearly half of all physicians in America still rely on paper records for most patient care, and time is running out to take advantage of the government incentive payments. So practices like Colorado Springs Internal Medicine are scrambling to get with the program.

Nearly 200 patients will cycle through the office on any given day. Doctors and staff pop in and out of exam rooms and offices constantly, carrying big stacks of manila folders holding patient charts.

Just behind the front desk, **Jay Kinsman**, MD, stands at the practice's information nerve center. "There'll be probably 500 pieces of paper come in on the fax, two times, three times a day," he chuckles. "If that goes down, we might as well close."

He is only half-joking. They have a back-up fax machine just in case.

About a year ago the practice decided it's time to switch to an electronic health record system (HER), and Kinsman took charge of shopping for the right one. He quickly felt overwhelmed.

"Do we really need 250 different EHRs, and 30 fairly widely used ones and 15 really big ones?" he asks. "Could we get by with one? Would we do better with just one product?"

Actually, there's closer to a thousand products out there. The market exploded when the federal government started offering doctors incentive payments to buy them. The government also said that those who don't go digital will face payment penalties in the future. So, all across the country, doctors like Kinsman are taking sales calls. His decision will directly impact not only his and his partners' days, but also everyone's incomes.

He explains, "When we were starting to think about this, we were hearing dollar figures on the order of $40,000 per physician to purchase an EHR and install it, and then lost revenue in the first two or three or four months. Basically we're planning on seeing only half as many patients a day for the first two to four weeks."

There are also decisions about computer hardware — laptops or tablets in the exam room? Host the system on their own server, or in the cloud? Hire an IT specialist, or outsource it?

Vexing as all that is, the practice's business manager, **Vicky Bonato**, says it's probably not even their biggest challenge. "Having everybody have a positive attitude to do it. If we could all keep positive and just get through it and learn it, I think we'll be OK," she says.

Not every doctor in the practice is equally enthusiastic about switching to electronic records. **Mike Spangler**, DO, has been practicing medicine for 40 years. He's not convinced that going digital is going to improve things. "It's going to take a lot of time, it's going to decrease productivity," he says. "And it's going to be very expensive. So, it means kind of three strikes against it and not as many strikes for it."

Spangler isn't just griping. **Margret Amatayakul**, RHIA, CHPS, CPHIT, CPEHR, FHIMSS, a consultant who's written about digital health records, says the experience leaves a lot of doctors frustrated. "Especially when people are finding that they bought a product and now are not happy with it. It wouldn't surprise me if there would be two or three times a replacement process before things settle down for any given practice," she says.

The message from the federal government is much more upbeat. It says American medicine is making great progress toward reaping the benefits of the digital age. The White House says more than half of U.S. doctors are now using electronic records in a meaningful way, and the Obama administration's head of health information technology says digital records will transform the practice of medicine. ■

COMING IN FUTURE MONTHS

- Combat top reasons staff members leave access
- Prepare for surge in subsidized coverage
- Avoid pitfalls with updated job descriptions
- Use patient portals to collect balances

EHR adoption said steady but slow

Physicians are continuing to adopt electronic health records (EHRs) at a steady pace, but more work is needed to have those systems communicate with each other. This statement is according to two studies published in Health Affairs magazine and reported by the National Association of Healthcare Access Management (NAHAM).

The first study used data about EHR adoption from the National Ambulatory Medical Care Survey. The sample size was 10,302 physicians, with a response rate of more than 89%. Researchers found that solo practitioners' EHR adoption rate grew by more than 127% from 2010 to 2012, but that they still were half as likely to have a basic EHRs as those in groups with 11 or more physicians. Specialists were less likely than primary care physicians to have adopted basic EHRs in 2012, unchanged from two years prior. Finally, basic EHR adoption among physicians 65 and older doubled between 2010 and 2012, but that age group was still the least likely to have a basic EHR. The study defined a basic EHR as having seven capabilities including recording patient history and clinical notes, viewing lab results and imaging reports, and using computerized prescription ordering. Overall, the study found that the number of EHR adopters was up from just more than 25% in 2010.

The second report, also published online in Health Affairs, focused on information exchange. Researchers found that 30% of hospitals and 10% of ambulatory practices participated in one of 119 health information exchanges in 2012. These numbers were more than double the 2010 statistics. For this study, researchers surveyed 322 organizations who could potentially engage in a health information exchange. The exchanges promote interoperability, or the ability of EHR systems to throw and catch patient data between health systems or between hospitals and physician offices, or between physician offices and labs or pharmacies.

Interoperability within the industry remains a challenge for the healthcare industry, according to the National Coordinator for Health IT at the Centers for Medicare and Medicaid Services (CMS). A survey last year found 71% cited interoperability as a major barrier to further EHR implementation.

You can view the original article from MedpageToday, with links to both studies, at http://bit.ly/1alGXrz. ■