

Patient Access ADVISOR



INNOVATIVE SOLUTIONS FOR THE FRONT END

Now is the time to prepare for the RAC program

**Medicare RACs recover \$12.7 million
in MSP errors**

Editor's note: Coming in October, PAA begins a series of stories on the Medicare Secondary Payer (MSP) Questionnaire.

Most of your peers in the revenue cycle are not fully prepared for the 2010 arrival of the Medicare Recovery Audit Contractor (RAC) program.

HCP's RAC Preparedness Survey polled patient access and patient financial services managers across the country in July about the nationwide program beginning January 1, 2010. Nearly 75% of survey respondents said they need more preparation for the arrival of RACs at their facilities.

Only 12% said they are "very prepared," whereas 36% said they are "somewhat prepared," and another 37% said they are "prepared, but not enough." The remaining 18% said they are "not prepared at all."

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See how one facility increased its collections in the ED from \$2,000 to nearly \$30,000 in one month.

In addition, 11% said they are "not very knowledgeable" about the RAC program and the results of the three-year demonstration project in New York, Florida, and California. Forty-eight percent said they are "somewhat knowledgeable," and 40% said they are "quite knowledgeable."

"That's a little scary that 48% said they are 'somewhat knowledgeable,'" says

"When it comes to filling out the Medicare Secondary Payer Questionnaire, it is critically important to make sure that you complete all the fields accurately and completely."

—Michael S. Friedberg,
FACHE, CHAM

Karen Feeley, director of patient financial services at New York-Presbyterian Hospital.

MSP form is an issue for facilities

As a patient access manager, you need to be prepared now for the nationwide rollout of RACs, especially in light of the \$12.7 million CMS collected through the MSP RACs in the three-state demonstration project.

More than \$1.03 billion in Medicare improper payments were collected—\$980 million in claim RACs, and \$12.7 million in MSP RACs.

CMS decided to discontinue MSP RACs and include MSP issues in the jurisdiction of the other RAC contractors. However, compliance with MSP requirements is more crucial now than ever before. And that means better training and ensuring staff competency through testing before the RACs come to your hospital, patient access experts say.

"When it comes to filling out the Medicare Secondary Payer Questionnaire, it is critically important to make sure that you complete all the fields accurately and completely," says **Michael S. Friedberg, FACHE, CHAM**,

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HCP

RACs

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director of patient access services at Apollo Health Street in Bloomfield, NJ. "Incorrect completion of the forms can result in Medicare's incorrect selection as primary payer. On audit, this can subject your facility to a negative financial impact."

However, most of your peers are not as prepared for RACs as they should be.

Feeley, the RAC liaison for her facility, spoke at a panel that included a talk on RAC preparedness at the June ANI: The Healthcare Finance Conference sponsored by the Healthcare Financial Management Association in

Las Vegas. The picture was very much the same there, she says.

"They don't know what to be prepared for," Feeley says. "I don't think anybody's really ready. It's difficult to really be ready until the RAC starts up in your state."

But people should be ready now, says **Linda Fotheringill**, a founding member of Washington & West, LLC, in Baltimore and the law firm Fotheringill & Wade, LLC, who specializes in overturning RAC appeals and Medicare denials.

Despite starting the nationwide program in 2010, the RACs will be looking at claims as far back as October 1, 2007.



"Hospitals think they have time to worry about this later ... but when the RAC does come calling, they are going to be looking at accounts as of October 1, 2007," Fotheringill says. "All of [the RACs] are charged with protecting the Medicare Trust Fund. And the bottom line is it's going dry. They're going to be aggressive."

Managers recognize importance of planning

Some promising news from the HCPro survey is that most respondents seem to realize where the energy should be early on in the RAC planning: 78% chose "select key players for RAC team" as an important first step. Many patient access managers also recognize the value of getting ahead of the game—81% said developing an internal audit process to identify risk before the RACs arrive is important.

The role of patient access is going to expand, Feeley says, because many denials are coming from errors in one-day stays, observation status, and medical necessity. Feeley says questions about who's booking surgeries and the correct way to book them need to be answered, and notes that case management also plays a role.

Asked how they see their role in RAC preparation at their facility, most managers seemed to be on the right track, Feeley says. Here are some of the survey responses:

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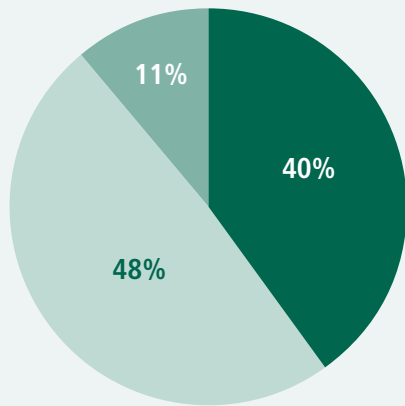
- “Ensuring that the right tools and people are in place to track receipt of letters, timely responses, chart reviews and rebilling/follow-up as appropriate. Organizing meetings to coordinate efforts and report results.”
- “Keeping updated with all news releases and following the audit process to see where our facilities’ greatest weaknesses are regarding what the RAC is looking for and ensuring we are addressing our facilities’ weakness by correcting them.”
- “I am working closely with our compliance department to set up a streamlined approach to deal with

the RACs. This includes educating other areas such as billing, utilization review/utilization management, coding, and clinical administrators who will need to be involved if and when their areas are involved. Once we begin receiving requests, most of my time will be spent in defense auditing and appeals.”

- “Participating as a team member on our group and leading preparation on the billing and registration side for RAC, coordinating with other areas, coders,

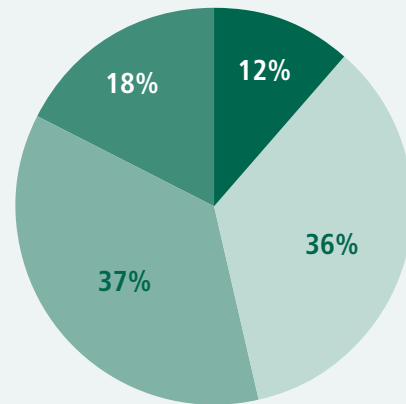
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RAC Preparedness Survey



How much do you know about the Medicare recovery audit contractors (RAC) and the results of the three-year demonstration project in New York, Florida, and California?

Quite knowledgeable ■ Not very knowledgeable ■
Somewhat knowledgeable ■



How prepared would you say your facility is for the arrival of a RAC?

Very prepared ■ Prepared, but not enough ■
Somewhat prepared ■ Not prepared at all ■

What are the most important things to do in order to prepare for a RAC?

Decide on one RAC liaison	43%
Select key players for a RAC team	78%
Schedule routine calls/meetings to discuss any/all RAC correspondence and necessary actions	50%
Access and review your state’s Program for Evaluating Payment Patterns Electronic Report data for potential areas of risk based upon the demonstration project	54%
Have a good tracking tool available	68%
Develop an internal audit process to identify risk before a RAC occurs	82%
Develop a fail-safe MSP program	35%
Understand the quality component of compliance in the facility	38%
Maximize the appeal process	53%
Train internal staff members to respond to RACs and incorporate changes into the compliance program	65%
Other (please specify)	11%

Source: HCPro’s RAC Preparedness Survey.

RACs *< continued from p. 3*

[utilization management], accounting, and developing documentation.”

Appeals a key part of planning

It will also be important to get your appeals process in place, Fotheringill says. She offers the following tips to get your appeals process started:

- ▶ Make sure you have a process in place where you can recognize a notice of denial and get it to a team that takes action in a timely fashion.
- ▶ Make sure the reviewer has training and proven competency in how to analyze a case with respect to standards of care and relevant Medicare regulations.
- ▶ When sending in a medical record with your appeal, send the entire record. Do not send abstracts or bits

and pieces. The record should be paginated and sent in a way that you can prove its time of receipt.

- ▶ If a hospital is appealing cases internally, and it is not successful at the RAC or fiscal intermediary level, it should consider outsourcing, since all evidence must be presented at the qualified independent contractor level.

Most importantly, Fotheringill says hospitals simply need to fight back on inappropriate denials or retractions. CMS reports that providers chose to appeal only 14% of the RAC decisions. Of all the RAC overpayment determinations, only 4.6% were overturned on appeal. Fotheringill says cases that are denied for alleged medical necessity issues can often be overturned on appeal if appropriately presented. ■

Facts about recovery audit contractors

What you need to know to get ready for the nationwide rollout

Prepare for the 2010 Recovery Audit Contractor (RAC) program rollout with these facts and figures provided by CMS and **William Malm, ND, RN**, practice director for revenue cycle management at HCPro, Inc., in Marblehead, MA:

- ▶ **Getting started.** The original RAC demonstration project, which ran from March 2005–March 2008, had two objectives: to detect and correct improper payments.
- ▶ **RAC program mission statement.** The RAC program’s mission is to “reduce Medicare improper payments through efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments.”
- ▶ **Whose reports are used?** RACs use reports from the OIG and the Government Accountability Office.
- ▶ **Three guinea pigs.** California, Florida, and New York were the first three states to be audited by RACs. In 2007, the demonstration project expanded to Massachusetts, South Carolina, and Arizona.
- ▶ **Cash motive.** The RACs are paid on a contingency basis; they get a percentage of the money they recover.
- ▶ **Show the government the money.** The RACs corrected more than \$1 billion of Medicare improper payments from 2005 through March 27, 2008. Roughly 96% of the improper payments (\$992.7 million) were overpayments collected from providers, and the remaining 4% (\$37.8 million) were underpayments repaid to providers.
- ▶ **Trust in Medicare.** Between 2005 and March 2008, \$693.6 million in improper Medicare payments was returned to Medicare trust funds. This accounted for money returned to providers through appeals.
- ▶ **Review period.** The look-back period changed from four years to three years, and the maximum look-back date is now set as October 1, 2007. ■

Make the most of your assessment

Tools to improve your registration department now that review is done

by Steven G. Orvis, MPH

Editor's note: This article is the second in a two-part series. The article in the August PAA focused on areas to assess within your registration process.

In the August PAA, I outlined some specific issues you should address in order to assess the quality and comprehensiveness of your registration process.

This article will discuss various recommendations for addressing and resolving these issues. Although these recommendations have a proven track record, keep in mind that your priorities and solutions will vary based on many factors, including your specific flow, internal policies and procedures, and physical setup.

In addition, please note that these recommendations are proposed at a high level and will need to be comprehensively detailed as you address them.

Centralization vs. decentralization

Although decentralization of registration processes is not inherently positive or negative, it often leads to a duplication of efforts and inconsistency among sites.

In addition, procedures and processes often lack standardization, as do specific responsibilities of job functions such as scheduler and registrar.

The following are some tips on how to make the move to centralization:

- Explore the possibility of creating a centralized management function. Registrars would physically remain in each registration site and be in close contact with their clinic manager, but all registration functions would report to one director and/or supervisor. This will:
 - Provide a greater level of consistency among registration sites
 - Improve the education and training process
 - Ensure that auditing and follow-up processes are performed accurately and appropriately

- Consider centralizing the registration functions as much as possible. One site might be able to register and schedule patients for two or three different sites. This would improve customer service and accuracy. Volume and physical location should be considered when deciding on the sites to centralize.

Registration as part of the revenue cycle

Often, front- and back-end staff members do not understand how their actions affect other areas of the revenue cycle. As a result, accountability is not always placed where it belongs.

To address this, managers should:

- Incorporate patient access management as an element in a comprehensive revenue cycle approach. This should include training on the *OIG Work Plan* for clean claims, Sarbanes-Oxley, and consequences (in terms of customer service and delayed revenue) of registration errors.
- Have front- and back-end staff members spend some time shadowing each other.

Customer service

Focus on registration accuracy and the highest level of customer satisfaction as goals. Remember that everything you do regarding updated policies and procedures, flow, and quality assurance (QA) will improve customer service.

As mentioned in the first article of this series, you should quantify any customer service issues that arise from registration processes. Audit the number of calls received for specific registration mistakes, such as incorrect payer entered, wrong demographic information, and authorizations obtained by the patient but not entered into the system, and specifically address these issues.

Another way to quantify customer service issues is to count the number of mail returns during a certain period

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Assessment

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of time. This will give you an idea of the amount of incorrect demographic information that is being entered.

Data integrity

Data integrity incorporates several issues, but all will affect the accuracy of the registration and demographic data you obtain. Registrars need to understand Medicare and Medicaid requirements, how to read insurance cards, and what information is required for the claim to be paid. To achieve this, you should institute a comprehensive training program. You must have an effective QA process to monitor the accuracy of the training, and results of this QA process will circle back to the training. To ensure that your training program is effective, consider the following:

- Learn what the plans and payers need to be able to pay claims. Most payers publish their requirements, and information is also available in provider manuals, online, or by contacting the payer.
- Determine the appropriate scope of service, such as “Under what conditions are payments made for this service?” and “How and to what degree will the service be covered by Medicare or Medicaid?”
- Create (or enhance) classes for staff members on how to read insurance cards and how to identify what information should be entered into the registration system. Attendance at these classes must be mandatory.
- Create tools and processes for formal and consistent QA. At a minimum, audits should be performed on a percentage of registrations, looking at the field in which errors are most likely to prevent a clean claim (e.g., Master Patient Index, insurance card information,

and account notes). Review each field against the source documents and document the errors found, as well as resultant training needs.

- Track and monitor the overall effectiveness of the QA process for at least six months. This will ensure that there is a working process, consistent reporting, and a reasonable accuracy target.

Policies and procedures/job descriptions

You should always have current job descriptions that are understood by staff members. In addition, policies and procedures must be documented and available to all staff members. Make sure you do the following:

- Review and update all job descriptions, and ensure that staff understand the functions for which they are responsible
- Develop a staffing plan by estimating the time needed to complete tasks and setting realistic productivity expectations
- Obtain quantitative performance expectations for each staff position, as well as projected volumes (e.g., the number of calls and number of patients seen)
- Set benchmarks that guide workload planning and performance
- Institute a solid work plan for staff members
- Sort responsibilities, delineate tasks, and structure functions to streamline supervision and improve task consistency

Financial screening

As mentioned in the first article of this series, the registration process must include financial screening. The following are steps you can take to ensure this:

- Redefine the policies and procedures based on any enhanced screening processes implemented for the financial sponsorship program. This includes all applicable federal, state, and local programs.
- Create financial sponsorship protocol and scripting tools.

Questions? Comments? Ideas?

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- Implement industry-standard processes, such as financial counseling and finalization of payment arrangements prior to date and delivery of service and identification of credit risk patients.
- Create quality indicators and key metrics to track the effectiveness of the financial sponsorship program.

Software tools

Whether you have purchased software tools or are using home-grown systems, you should have appropriate scrubber tools, registration and eligibility verification software, and medical necessity software. The following are quick tips to consider before purchasing these tools:

- Ensure that your scrubber flags the accuracy of registration data before the claim errors out of the system. In addition, the software should allow users to build edits or rules against the registration fields that automatically flag potential errors.
- Research software that validates the guarantor address used to mail statements to self-pay patients. This will reduce the number of bad address statements.
- Use medical necessity software that creates a customized list of services that physicians regularly provide. Based on diagnosis or procedure, the software determines whether the service meets medical necessity and will generate an advance beneficiary notice as necessary. The software can also check, prior to service, whether Medicare or the primary payer will pay for that procedure or item.

Evaluation of any software should include the following questions:

- Does the software directly integrate with existing information systems?
- How will it affect existing processes and work flows?
- What type of reporting is available?

Communication with contracting

To optimize communication between the contracting department and your front-end team, consider doing the following:

- Provide the contracting department with an issues list from the staff regarding the highest-volume payers.
- Have contracting work with front-end managers when contracts are renegotiated. This includes meeting with front-end staff members/management prior to new contracts being implemented so that all major provisions are understood by the staff.
- Ensure that members of contracting attend any meetings held between payers and staff members.

Denial management

The following strategies can help prevent denials:

- Incorporate two parallel processes in the denial management process: prospective prevention and claims recovery
- Institute a systematic approach, including objectives and goals, schedules, and action plans
- Invest in systems to track and report denials
- Develop standards for reporting types of denials and communicate them throughout the organization
- Assign responsibility for denials and reward staff members for improvement
- Measure results on an ongoing basis

Assess the entire registration process

There are as many solutions available as questions to be addressed as you assess your registration process. The most important point to remember is that you should have a systematic approach to assessing your entire registration process (not just one aspect at a time), prioritize your issues, and create solutions that will be workable in your facility. Keep in mind that any errors that occur during the registration process will reoccur throughout the entire process, including billing and collections, so it behooves registration managers to make accuracy a top priority. ■

Editor's note: Steven G. Orvis, MPH, is a healthcare consultant who has more than 25 years of progressive experience in physician and hospital business office and outpatient services management, in addition to performance improvement consulting. He is manager at a consulting firm in Los Angeles.

Copayments could be reduced under OPSS proposed rule

CMS' 2009 Outpatient Prospective Payment System (OPSS) proposed rule might lead to a reduction in the copayment amount for services at hospitals that have not met their quality measure reporting requirements.

Hospitals reporting required outpatient quality measures in 2009 will receive a 2% inflation update. Hospitals not reporting these measures will not receive this update.

Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance at HCPro, Inc., in Marblehead, MA, says this proposed rule does not appear to have a great effect on patient access.

Sandra J. Wolfskill, FHFMA, president of Wolfskill & Associates, Inc., in Chardon, OH, agrees. However,

she notes that the proposed rule does have implications for ordering patterns of physicians, especially in radiology if the proposed single-payment clause stands. CMS seems to believe that certain high-dollar radiology tests should be done one at a time rather than in bunches, she says.

"My guess is that providers will scream loud and long, and we may see a change in the final rule," says Wolfskill.

The proposed rule also includes changes for Type B EDs and imaging services as well as expansions to quality measures.

CMS requests comments on 18 additional quality measures for potential inclusion.

Among the measures are ED processes, screening for fall risk, and management of clinical conditions such as depression, osteoporosis, asthma, and community-acquired pneumonia.

Under the proposed rule, CMS will put a data validation program into service for hospital quality data, effective January 2009.

The proposed approach selects 800 reporting hospitals and validates reported data using 50 records per selected hospital annually.

New APCs for some Type B ED visits

Currently, CMS pays for emergency visits provided in Type B EDs, which offer emergency-level services but are not open 24/7, at the same rate as a non-emergency visit to an outpatient department.

CMS data show that most Type B emergency visits are more expensive than clinic visits but are less expensive than Type A ED visits.

The proposed rule creates four new APCs for Type B ED visits, paid based on claims data from these providers.

CMS has also proposed to pay for the most intensive emergency visits using one APC on the premise that costs for these are similar in Type A and B EDs.

Upcoming event

Learn to make the right call

The challenge of properly classifying a patient as observation or inpatient is essential to ensure compliance and revenue integrity. And getting the decision right affects the clinical and financial worlds.

Join HCPro at the Observation Status Symposium at The Ritz-Carlton in New Orleans, October 2-3. This day-and-a-half-long seminar takes on a new format this year. In addition to learning how recovery audit contractors look at observation status and one-day stays, you will learn how to:

- Tackle the wide-reaching effects of assigning inappropriate patient status
- Implement processes and strategies to bill correctly
- Apply Medicare's definitions of inpatient and observation
- Uncover the critical aspects of medical necessity, revenue integrity, and utilization review

The seminar includes an open Q&A, during which you can ask all your pressing questions, as well as a case study panel discussion series.

For more information or to sign up, please call 800/801-6661 or visit www.hcmarketplace.com.

Changes in imaging services payments

The OPPS proposed rule uses one payment for certain multiple imaging services when provided in one session. Services affected by the proposed rule include:

- Ultrasound
- CT and CT angiography (CTA) without contrast
- CT and CTA with contrast
- MRI and magnetic resonance angiography (MRA) without contrast
- MRI and MRA with contrast

“This is not good,” says **Glenn Krauss, RHIA, CCS, CCS-P, CPUR**, an independent consultant in Milton, WI. “You used to get paid for two modalities [in multiple imaging services] and you got discounted on one, but now you’re only going to get paid for one. [CMS] is telling us to be more efficient and think twice about

ordering. What they’re doing is practicing medicine.” CMS has proposed these changes in an effort to eliminate unnecessary tests, and although Krauss says this problem exists, he asks, “But what happens if [a test] is necessary?”

Krauss says he foresees the changes posing a lose-lose choice for radiology departments. To run efficiently under the new rule, radiology departments must change their ordering patterns—but doing so might catch CMS’ attention, Krauss says.

CMS will respond to comments in a final rule that it expects to release on or before November 1. Should the changes become final, they will take effect January 1, 2009. ■

Editor’s note: To view the OPPS proposed rule for 2009, visit www.cms.hhs.gov/HospitalOutpatientPPS/HORD.

Case study

Solidify your ED copayment collection policy

Get clinical team on board; offer incentives to staff members

The patient access team at Houston Medical Center in Warner Robins, GA, did not have the best luck collecting copayments in its ED.

“Our copay collection process had never been super good,” says **Rhonda Carpenter, BSBA, CHAM**, director of patient access at Houston Medical, a 279-bed facility that sees 600,000 patients per year.

Carpenter says the clinical team didn’t have a large enough role in the process. Patient access staff members did not buy into the system. There was no established way to ask patients to reach into their wallets before they left.

Now, thanks to an effort dedicated to boosting its copay collections in the ED, Houston Medical has seen an increase from \$2,000 in collections per month to nearly \$30,000 in June.

Carpenter credits the success to a new system called REACT, in which a discharge nurse sees patients in the registration area after they have been cleared to go home.

At that point, registrars already have the financial information they need to determine the copay amount. They collect that at check-in, unless the patient goes straight to the ED in the case of a more severe illness (see “Cost estimate” on p. 11).

“That discharge nurse sits in our registration [area] and is the very last person to see patients,” Carpenter says. “That’s made a huge difference. It became part of the process. If we’re going to get a person discharged, we’ve got to take them to registration. Until now, it was really hard to get [clinical team members] to understand that the collections we get are helping to pay us all.”

The discharge nurse is not the only reason Houston Medical saw its ED copay collections grow so rapidly. Other aspects that contributed to the success include:

- **A comprehensive policy and procedure.** The policy mapped out the copay collections process and

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ED copayment

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helped greatly when the idea was pitched to senior management.

- **Staff incentives.** Monthly and quarterly, Houston Medical's patient access team posts who collected the most money. The team presents rewards, such as gift cards, each month. If a registrar has a great month, the chief financial officer will go to the registration department with Carpenter and "make a big deal about it," Carpenter says. "We encourage them and tell them what a good job they did. Everybody got on board and even started to become a little competitive."
- **Increased involvement of registrars.** Carpenter involved staff members in the creation of a scripting tool (see the enclosed Training Tool for more detail). Initially, they did not feel comfortable with it because it felt rehearsed. "At first, there was a lot of negative response and complaints," Carpenter says. "We're trying to meet patient satisfaction, but they're not happy because you're collecting money from them. We got together to decide what scripting was comfortable."
- **Software that triggers copay collection.** Houston Medical's registrars use a software system that produces pop-up screens that makes it easier to identify

the existence of a copay. "Having the right information in front of them so they know what to ask for is so important," Carpenter says.

- **Broad exposure of its collections policy.** Houston Medical has signs in the registration area informing patients that they will be asked for a copay. "They know we're going to ask for it," Carpenter says.

The biggest hurdle to successful ED copay collection is fostering a relation between clinical staff members and patient access, says **Jane Severs, MHA, CHAM**, director of patient access at Beebe Medical Center in Lewes, DE.

Severs says her system involves checking eligibility through its software system or on payer Web sites to determine the copayment.

Registrars then know what to ask for when patients speak with them.

The nurses at Beebe are in constant communication with registrars when they discharge patients.

"The biggest thing is communication between registrars and the clinical staff," Severs says. "You have to develop a relationship where you make sure it works out." ■

Tip of the month: Create a managed care plan matrix

It is useful to have a contracted insurance matrix that patient access staff members can use as a reference guide to identify which plans have managed care requirements. The matrix should include the following data elements:

- A complete list of all contracted healthcare plans.
- Types of plans included in the contract (e.g., HMO, PPO, POS). Listing the included plan types is crucial. Do not assume that the contract includes all plan types.
- All contact numbers.
- A list of services requiring precertification by plan type. Often, insurance plans have different precertification

requirements (e.g., HMOs might require precertification, but preferred provider organizations might not).

- Services that require referral or notification requirements.
- Reimbursement penalties if authorization is not obtained. ■

Editor's note: This tip was featured in The Patient Access Director's Handbook, by Sandra J. Wolfskill, FHFMA, and Marilyn Lipka, published by HCPro, Inc.

This Month's
Form

Editor's note: This form is used by the patient access team at Houston Medical Center in Warner Robins, GA, to explain to patients the estimated costs associated with their care.

Cost estimate

Patient name: _____

Patient account number: _____

This is an estimated cost of your services today. We cannot give you an exact cost at this time because there might be additional charges we cannot predict.

The estimated cost of your service is: \$ _____

Your copay and/or deductible due today is: \$ _____

Our 20% prompt-pay discount is: \$ - _____

Total estimate due: \$ _____

Please sign that you acknowledge this is only an estimate of your charges. You may be billed later for any additional charges.

Patient/guarantor signature: _____

Registration representative: _____

Date: _____

 Download this entire form in the **Patient Access Advisor** section of www.accessresourcecenter.com.

Source: Houston Medical Center, Warner Robins, GA.

Keller named to PAA advisory board

PAA named **Debra Keller, CHAA**, to its advisory board in July.

Keller, the admissions/registration director for the Grand Itasca Clinic and Hospital in Grand Rapids, MN, has more than 20 years of experience and manages 35 employees in the clinic's call center and registration and admissions offices. Keller is an active member of the National Association of Healthcare Access Management. She is also the president of the Minnesota Health Access Management Association.

Keller says patient access is on the cusp of an era of technology in which most appointments are made from home and facilities have kiosks and smart cards.

"Keeping your front access lines in that direction is what I see," says Keller, whose multispecialty clinic has 48 physicians in 12 specialties. The 64-bed hospital and clinic are located in a state-of-the-art facility built in 2005. "Yes, you will have to have a person still there, but technology is going to become more important," she says.

Medicare is also something patient access teams are going to have to stay on top of, Keller says.

"Medicare has been just explosive in the last five years with ... types of coverage," she says. "All that is changing."

To lead a successful patient access team, Keller says you need the following:

- **Buy-in from CFOs.** Facilities can no longer hire full-time equivalents (FTE) as a budget consideration. The number of FTEs has to be in line with how many registrations you have.
- **Ability to adapt.** "We have to evolve weekly, monthly, yearly," Keller says. "If you get a clean bill, you're going to get a faster turnaround. Front access is going to make or break any institution. Give me the hardware and software, and let's relook at what our standards are and change with the times."
- **Cohesion with patient financial services.** "Staff members should get together for weekly huddles where training is involved for both departments," Keller says. "We have to broaden that understanding of one another." ■

"We have to evolve weekly, monthly, yearly. If you get a clean bill, you're going to get a faster turnaround."

—Debra Keller, CHAA

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Scripting tool

Editor's note: The following scripting tool is used by Houston Medical Center in Warner Robins, GA, for collecting copayments in the ED.

Patient access

Scripting tool: Coinsurance & deductible amounts

Greeting: Greet the patient with “hello,” “good morning,” or “good afternoon.” Say:

My name is _____, and I will be doing your registration today. I need to review some of your information. We want to be sure we have complete and accurate information to bill your insurance. Don't forget to smile and make eye contact.

Go through the registration process. When you come to the end of the process, you will need to discuss payment options. For those patients with estimates for outpatient surgery, lab, x-rays, and other ancillary tests, say:

I have prepared an estimate of your charges today. (Show patient the cost-estimate sheet.) When you pay today, I can offer you a 20% discount. For your convenience, we accept cash, check, debit card, and all major credit cards. How would you like to pay your estimated portion today?

If the patient states he or she cannot pay today or asks whether he or she has to pay today, you should say:

Your estimated cost share is due at the time of service.

If the patient states he or she cannot pay (or pay the full amount) today, you should say:

How much would you be able to pay today?

If the patient then says he or she can pay a portion of the full amount, you should say:

Yes, I can accept that, Mr./Mrs. _____.

Proceed with the agreed amount/arrangement. Remember, if the patient claims financial hardship, offer him or her the financial assistance packet.

Patient access

Scripting tool: Copayments (ER or Med-Stop)

Greeting: Greet the patient with “hello,” “good morning,” or “good afternoon.” Say:

My name is _____, and I will be doing your registration today. I am sorry an emergency brought you here today. I hope things are better now. I need to review some of your information. We want to be sure we have complete and accurate information to bill your insurance. Don't forget to smile and make eye contact.

Scripting tool (continued)

Go through the registration process. When finished, you will need to ask for the patient's copayment. Say:

Mr./Mrs. _____, your insurance policy shows that you will owe a \$___ copayment for your ER visit today. For your convenience, we accept cash, check, debit card, or any major credit card. How would you like to pay today?

If the patient states that he or she cannot pay today for any reason (e.g., he or she didn't bring a checkbook or doesn't have money), you should say:

What would you be able to pay today? I can offer a 20% prompt-pay discount if that helps determine what you can pay today.

If the patient claims financial hardship, offer him or her the financial assistance packet.

Patient objection scripts

"Why is the price so high?"

Our prices are competitive with other hospitals in the area, and our services are excellent.

"My insurance pays for everything."

We have verified your insurance, and there is a deductible/copayment associated with your treatment today; it is your responsibility. Your insurance covers a percentage of your total bill, and you are responsible for the remainder, according to your insurance contract.

"I didn't bring my checkbook."

That's okay, we accept cash, debit cards, and all major credit cards. How would you like to pay today?

"My ex-husband/wife is responsible for all the child's medical bills."

I understand that you may have an agreement with your former spouse. I will be glad to give you a receipt so that you can have him or her reimburse you. Will you be paying today by cash, check, credit, or debit card?

"All you care about is getting my money."

I can assure you that your care is our foremost concern. However, even though your health and welfare do come first, we have to ensure that we can pay for that care and offer the highest quality possible. You have our apologies for placing what appears to be a high emphasis on payment, but this is a critical aspect of your care.

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

Since you were last here, we have made changes to our processes that no longer allow us to delay collecting copayments, deductibles, or coinsurance amounts. By taking care of the bill now, you can avoid worrying about a bill later.