THE HEALTHCARE BUSINESS LETTER

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Obtaining & Maintaining Key Demographic Information

Patient Satisfaction, Billing, and Privacy Issues

By James A. Muschler and Karen A. Schumacher

Front Office Staff

When a business traveler checks into their hotel for the night, it is the individual who manages the registration desk who creates the initial business image and service quality perceptions. Who is the individual in our practice who has the greatest impact on patient perception?

Our investment in these key people should directly reflect the impact they have on our patient loyalty and satisfaction ratings. The most common finding in our current healthcare environment is these are the poorest trained, lowest paid, and highest turnover individuals at our practice.

This post should not be considered an entry-level position. These individuals, who manage customer interactions at the front desk, must be able to perform a multiple of tasks with the personal skills and problem solving abilities of a seasoned public relations expert. The patient's first contact with the practice is often the process of scheduling their initial appointment. The second most important moment is their arrival at registration. Today's front office staffer is one of the most crucial members of the team. They must be both sensitive to the patient's feelings and develop an atmosphere of both personal trust and mutual accountability.

Healthcare's increasingly complex reimbursement environment, and the growing push to collect both more complete and detailed demographic information at the time of service, requires upgrading staff skill sets, increased pay scales, measured accountability, strategic financial controls, customized training and competency-based incentive systems. Patient financial service professionals need specialized skills to transition into the future of patient and healthcare consumer relationship management. To meet the daily challenges, patient financial services professionals need the skills necessary to meet the customer's demands and perceptions regarding the quality of care being provided.

Patient health history, insurance and demographic data, financial status and self-pay amounts must be identified and communicated completely, clearly and without error. The front office staff is responsible obtaining treatment consents, release of information consents, necessary authorizations, assignments and maintained insurance card copies, drivers license, or state ID. For patient financial service professionals, many of the steps associated with each patient encounter are now computerized or automated, including the appointment scheduling and patient registration procedures. Medical record diagnostic coding may be entered directly into the database and the claims submissions may be handled electronically. If these encounters are not handled properly by the provider's staff, the result can be a patient who feels increasingly alienated from the system they depend upon to make them feel more human.

An increasing electronic processing of patient health information, encounter data, insurance claims, reimbursement status and remittance are here to stay. Capitation and managed care, as we currently know it, will disappear. New reimbursement methods will take their place. Practice resources will be reallocated to meet the needs of these future systems.

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With the coming of HIPAA, staff members will be spending far less time on the telephone chasing down the wide variety of specialized forms that have been customary in the past. With the new HIPAA compliant systems, copayment amounts will be quickly identified and collected in real-time, coverages will be verified on-line, and service and coverage will be authorized by the health plans all while the patient is sitting in your office.

The referral process will be easily administrated. The consent forms and any specialized authorizations will be coordinated through on-line, real-time links to the health plans. The front office staff will be required to have up-to-date and complete knowledge of all phases of third-party reimbursement. However, there will most likely exist, as there does today, a variety of stipulations for different managed care contracts which will only seem to exist to frustrate our efforts to maintain a clear and clean revenue flow. In other words, the legal aspects of the healthcare practice's cash management position will always have its unique set of challenges. There will always be hoops that are set for us to jump through in order to maximize our reimbursement levels, while attempting to minimize our costs of following up on these slow payments or claim denials.

Front Office Best Practices

Gathering Appropriate Patient Information

Physicians can no longer afford the risk of lost reimbursements due to information not being gathered up front. Practice managers must improve up-front processes to eliminate these losses of revenue. Beginning with information gathered during the scheduling call, improve compliance to information requests with the use of a professionally designed and printed welcome package.

To get you started, here is a checklist to assure you are requesting enough information to provide quality service for your patients:

- Who are the players? Patient, Guarantor, Spouse, Employer, Attorney, Case Worker
- Where are bills to be sent? Addresses for the above, including payor locations
- How can we contact them? Phone numbers for the above, including cellular number / pager and work numbers
- What method of payment will be used? Cash, check, credit card, debit card, preauthorized-debit, post-dated check.
- When can payment be expected? When is payment due? Do state insurance laws require prompt payment?
- Why is patient seeking care? Referring Physician, responding to an ad, etc.

Insurance Verification

In major metropolitan areas, an individual patient's insurance coverage changes, on average, every 18–24 months. This can become an issue each time a patient returns for follow-up care. To minimize denials due to outdated or erroneous insurance information, the patient's insurance coverage and benefits should be updated each time a patient returns. This has become a particularly acute issue recently with the Medicare managed care plans exiting the market.

Patients who have elected to change from the traditional Medicare fee-for-service program to a Medicare managed care plan, may find that their plan has changed under less than ideal circumstances.

Depending on practice procedures, certain clinical or billing staff may have specific responsibilities for either capturing patient diagnostic and/or procedural information. Individuals who are involved in either the auditing or the reviewing of coding functions should also be included in the maintenance and support of the practice's compliance monitoring and audit plan.

Electronic-based Documentation

EMR software usage is on the rise. Most practices have plans to moving in this direction, as the cost of these products becomes less prohibitive. The time will come, potentially within 10 years, where costs associated with performing 'manual' care coordination, business, and paper claim submission functions will prohibit practices from effectively competing.

Efficiency and effectiveness in information processing can take a multiple of forms. GIGO "Garbage in, Garbage out." To avoid common data entry errors, such as starting two separate patient accounts on the same individual because of an input error, misspelled surname, or shortened first name. One way to catch these errors is to verify the patient with a search by social security number (if you obtain this information) or a birth date.

Timeliness of submission is an imperative for speeding reimbursements or reducing costs. Claims for services rendered should be processed daily, yet many practices still 'save' claims until there is a volume of claims for mailing or transmission. The sooner a claim is mailed or transmitted, the sooner the claim will be paid.

Payments and EOBs should be posted immediately. Failure to do so opens the door to wasted effort and money on unnecessary billing/collection activities. In addition, continued billing and collection on paid balances creates negative customer service ramifications.

Billing and Collecting Power

Information creates power. Missing or erroneous information can weaken your organization and tap its resources. When the quality of information gathered and stored by a practice is poor, resources are drained through inaccurate communication of facts, resulting in a great deal of rework. Rework adds to the costs of business and reduces the potential of collecting past due balances. Cost of collections remains high, revenues decrease, employee moral deteriorates, and write-offs drain the life-blood from the practice.

To remain in business in today's healthcare marketplace, you must collect patient copayments at the time of services are rendered. To bill patients for copayments after services are rendered violates most managed care contracts. The patient must pay the copayment before the physician renders service. This is a requirement placed upon the providers by the payor to create a disincentive for over-utilization of healthcare services by members of each Plan. Collect any copayment before service, including any past due balances on the account. The patient exit staff must address past due balances before the patient leaves the office.

Submit claims for payment as soon as efficiently possible. Mail statements to patients in a timely fashion approximately every 21 days, identifying the entire balance owed. Each statement should indicate whether third-party insurance has been billed, whether any payments have been received from third-party insurance carriers, and also remind the patient or guarantor of their responsibility to pay any outstanding balance when insurance does not reimburse in a timely or complete manner. Staffers should be educated and trained on the most efficient and effective handling procedures to be utilized when third-party claims are not paid timely.

Checks & Balances - Making the system work for you!

Incorporate a 'Forwarding Service Requested' system on mailed statements going out of your office to patients with outstanding balances. The result will be to catch any mistakes in the patient or guarantors address and immediately update your database with the corrected information.

When you have returned mail, and have rechecked the address against your database, send to your collection agency. Agencies often have resources available to better locate the newly missing.

Handling Stalls

The Pen is always mightier than The Phone! Rarely is a collector's time well spent making outbound follow up calls to payors and 'checking status' of individual claims. Many a seasoned collector has fallen into this self full-filling maze of Muzak, stale voice-mail loops, and 'claim review' transfers. The truth is, we are often only justify the means, as we are just caught in an illusion of productivity.

SuperRep

Front office staff is responsible for introducing patients and their families to the portfolio of services offered by the practice. They are responsible for scheduling patients, creating a comfortable 'flow' of both information and money into the practice. They must instill confidence in the staff and physicians at the practice. They should identify what services are available to the patient and their family. They should create both a professional business environment as well as a trusting environment where healthcare services can be discussed with ease and in confidence. The patient, and their families, should leave feeling satisfied that their healthcare needs are both understood, and that they were given the chance to ask questions regarding their health status and treatment options. The excellent front office staffer must demonstrate the ability to explain and effectively resolve any and all patient financial issues within the written practice policy requirements.

Successful Front Office Staff Qualities

Professional and Personable – The successful patient advocate must appear professional each time a patient is served.

Understanding and Empathetic – In order to facilitate strong communications, it is important that the receptionist understand the patient's needs.

Empathy – The capacity to tune into the feelings and concerns of others, will help the successful patient rep to understand a patient's point of view. It is critical that the patient financial services professional is sensitive to the needs of patients and their families.

Assertive and Persuasive – A successful patient rep will have the persistence to obtain complete and accurate health history and registration records. The successful patient rep should possess the ability to express goals and objectives clearly without apologies or hostility. This factor is especially important when requesting payment.

Financially Focused – The registration person needed for success in today's healthcare environment must be aware of the financial aspects within the patient registration process.

Desire – The rep should be committed to meeting the personal needs of patients and of their organization. A positive mental attitude is a winning attitude!

Common Sense – A clear head and the ability to decide on the best course of action can help head-off even the most difficult patient encounters or tough, information-gathering registration problems.

Improving front office operations significantly improves the claims submission process. During a recent MGMA teleconference, Michael Green, Senior Vice President, Processing Services, Independence Blue Cross stated, *"[One of our biggest problems in] claims that fail compliance – initial point of entry during the adjudication process – eligibility, valid procedure code information, indication of other insurance, valid provider information (performing provider vs. billing provider), duplicates."* He further advocated the use of web access to check Benefits and eligibility and using the carrier's VRUs to do the same. Also, Green recommends improving posting timeliness, especially on denied services.

Providing bundled solutions to today's healthcare business office challenges

Instead, use a system of letters to counter the common stalls, which insurance companies employ to delay, deny or reduce reimbursement. The first step to implementing such a system is to make sure the practice submits clean claims. Invest the time up front to find common errors and determine a way to circumvent them.

Rebounding Denials

When a payor denies a claim, the biller or collector must act immediately. It is imperative to have procedures in place that requires staff members with access to the patient record and clinical information to review any claims that are rejected. If the reason for rejection is a clerical error, correct the error and follow up directly with the payor. The reason for rejection should direct the staff to not only correct the error, but create a change in processing or procedure to eliminate the same problem from happening again in the future.

Move the responsibility for billing to the front office. Make billing everyone's responsibility. In addition, basic tracking information like the dates of the denial review should be included in payor specific files. Provider organizations should also ensure the availability of the original documentation on which the denial challenges or audits were conducted. This includes the patients' medical records, encounter forms, remittance advice and EOBs.

Managing Protected Information, Once It Is Gathered

The HIPAA legislation, which is coming into activation now, has specific rules about protecting payor information. If a practice shares information with strategic business partners such as billing companies and collection agencies, they must have a Business Associate Agreement, which addresses the usage of PHI.

Mr. Muschler and Ms. Schumacher co-authored several of ARSI's Physician Practice Management manuals, which are available on the ARSI web-site.

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