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Patient Access Scripts

Support front-end staff with interactive scripting solutions

In her book, *Understanding Patient Financial Services*, author Christine Robinson-Crowley writes: "The business office of yesterday is the patient access department of today."

Indeed, the responsibilities of patient access departments today are far more comprehensive than in the past, with duties that encompass not only scheduling and admissions, but also reviewing referrals, obtaining authorizations, verifying eligibility, and requesting payment at time of service.

Recognition for Patient Access

With these new responsibilities, the patient access department has been recognized as having a major impact on the efficiency of a health care provider's revenue cycle. As a Healthcare Financial Management Association (HFMA) publication notes:

> It is not far-fetched to call scheduling and registration processes the 'face' of a hospitals' revenue cycle operations. A patient's first encounter with a hospital's revenue cycle typically occurs with these processes, and it is here where the patient forms his or her first impressions of the hospital.
>
> Patient access management has become the latest area of focus in the development of the hospital revenue cycle—with the promise of reduced denials and increased point-of-service cash collections.[1]

Talents, Tools, Technology

Recruiting, training, and retaining the work force to staff the patient access department—while keeping up with regulatory requirements and a highly complex billing environment—is costly and requires strong management and creativity. Health care providers increasingly are dealing with staffing issues in the patient access department, including high turnover rates, absenteeism, and workload levels.

As the health care environment becomes more and more complex, sustainable investment in staff tools and training, as well as proper recognition and rewarding of staff, is critical. Using technology such as a self-pay management solutions that complements a hospital's patient registration system is an effective means of streamlining, simplifying, and clarifying the patient access staff's responsibilities, resulting in an improved work environment and more efficient revenue cycle management.

Such a system can facilitate the collection of accurate patient information at registration and correct remittance. Producing customized, scripted information based on a service provider's own business rules, the system can intuitively guide patient access staff through complex revenue cycle processes, such as eligibility verification, demographic validation, payment assessment, Medicaid and charity care qualification, and pricing transparency—turning even the most inexperienced registrar into an expert.

Background

Many health care providers realize the key to an effective revenue cycle strategy that will increase cash flow and reduce administrative denials begins at patient access. They also realize that the traditional patient access model needs to be updated.

The patient access department has become a centralized information center, absorbing many functions traditionally performed in other locations.

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Often, however, patient access employees lack effective tools and support.

With the ever-increasing duties of the patient access staff, coupled with the lack of available tools and training, it is no wonder that mistakes happen. For example, many patients eligible for government and charity care assistance can slip through without their personal information verified, and without any financial counseling or collections.

When eligibility is not verified upfront, more patient claims may be denied, payments may be slowed, and more claims may need to be re-worked. For the growing number of self-pay patients, specifically, the only opportunity for reimbursement is to collect cash at point of service.

There frequently is a failure to properly value admitting, scheduling, and registration staff through appropriate pay levels and clear work guidelines. This results in high staff turnover rates in patient access and registration areas and, as a result, degraded revenue cycle performance. Often patient access personnel are some of the least compensated members of a service provider's team.

While many have been college educated, most are trained on the job. There is a critical need to streamline processes and to reinforce standards and training at the workstation.

Why have the responsibilities of patient access staff members increased so dramatically? The traditional revenue cycle model has evolved in recent years, with more attention being placed on front-end collections, making registration and admission areas the new "face" of the revenue cycle. As the model has changed, so have the duties of the patient access staff.

The Modern Revenue Cycle and the Role of Patient Access Staff

The revenue cycle is a continuous process, beginning when a patient is identified as requiring or requesting medical services and ending at the time payment is received and the account is closed. Traditional revenue cycle processing focused on post-service activities, with little attention given during pre-access and time-of-service activation. Current models of revenue cycle management focus on pre-access and time-of-service activity, all in the patient access area, including:

1. Comprehensive pre-access data validation and sharing;

2. Comprehensive/coordinated patient financial and clinical processing;

3. Anticipation of resource consumption;

4. Application and resolution on encounter and process edits;

5. Record/demographic completion and resource consumption posting; and

6. Financial monitoring.[2]

According to a December 2006 article in *Healthcare Registration*:

> Nearly every successful outcome used to measure the revenue cycle management process has roots in the front-end processes of patient access.[3]

The article goes on to note that best practice performance in patient access often leads to:

1. Improved data quality;

2. Increased net revenue;

3. Improved productivity/performance;

4. Increased cash collections; and

5. Reduced need to rework accounts.[4]

Clearly, improving patient access procedures can have a major impact on a provider's bottom line. Best practice strategies to improve revenue cycle performance can include patient access training, education and technology, increased staff recognition/rewards. The HFMA article noted earlier gives several examples of the intricate situations patient access staff deal with on a daily basis. HFMA notes:

> The complexity of the task facing [the patient access staff person] is too often underappreciated by hospital leadership. For example, hospital information systems use insurance plan codes to identify the various products offered by each insurance carrier. The patient access staff is rarely consulted when plan codes are assigned, but patient representatives must choose the correct plan code based on the insurance card presented by the patient.
>
> Insurance carriers also offer myriad products to employers including indemnity insurance plans, health maintenance organizations, preferred provider organizations, point-of-service plans, and more recently, health savings accounts. These products come in

> different flavors and sizes with different billing and notification requirements, further complicating the patient representative's task.
>
> The patient representative is expected to quickly decipher which plan the patient belongs to from the patient's ID card. [T]he patient representative's choice affects the manner in which the claim is sent to the carrier, and an incorrect choice can delay claim submission and often result in rejected claims and delayed payments.
>
> Managed care agreements have added another level of complexity. Patient representatives must know when to obtain preauthorization and referrals, and to verify the appropriateness of the place of service. Even the most sophisticated 'managed care matrix' cannot address every scenario for every plan.[5]

Offering patient access staff members effective, integrated tools, such as a self-pay management system, can improve the work environment and reduce frustration with the process (or lack thereof). Such a system can provide patient access staff with real-time scripting, to ensure more efficient dialogues with patients and/or physician offices. The dialogue will flow naturally and allow employees to capture all required data, including complete patient demographic data, correct procedure codes and payer data so that any and all insurer requirements can be met.

The Benefits of a Self-Pay Management System

Implementation of a comprehensive self-pay management system enables health care providers to interact with all patients regarding financial responsibilities at the point of service, including offering price transparency and medical financing options. Such a system provides patient access with interactive scripts that integrate patient demographic information with each provider's unique business rules, thereby eliminating guesswork.

Coaching and scripting are powerful tools, saving a service provider time and money by helping patient access employees to avoid dangerous pitfalls due to inconsistent and inefficient practices. Real-time scripting at the workstation expands individual responsibility and reduces levels of management unless the process is an exception to normal business rules. Patient access staff's organizational structure and areas of responsibility continue to evolve; the information at their fingertips should do the same.

Conclusion

In summary, a self-pay management system can and should:

1. Enable patient access staff to consistently follow policies and procedures of the provider for collection of patient-due portions via online scripting, as well as ensure compliance with state and federal regulations;

2. Guide patient access employees in acceptable payment arrangements and discounts to be offered based on a provider's policies and procedures;

3. Flag accounts where patients may qualify for charity or local, state, or government assistance and guide registrars in steps that should be followed;

4. Verify patient address and other critical information;

5. Increase upfront cash collections and reduce outsourcing costs by placing the policies and procedures to follow, and necessary tools, at the fingertips of front-end employees; and

6. Provide real-time reporting to monitor registrar performance, collections, and compliance with policies and procedures. ■

Notes

1. *See* "Patient access: a new face for the revenue cycle," HFMA, March 2007.
2. *See www.tricare.mil/conferences/2003/UBU-UBO/downloads/r202Keel.ppt.*
3. *See* Willyard, David, "Patient Access Best Practices: Front-end processes are critical components of effective revenue cycle management," *Healthcare Registration*, December 2006, p. 1.
4. *Id.*
5. *See* "Patient access: a new face for the revenue cycle," HFMA, March 2007.

Reader's Resource

This article is reprinted with permission from an nTelagent issue brief, "Supporting Patient Access Staff With an Interactive Scripting Solution." For more information, go to the nTelagent Web site, at *www.ntelagent.com.*

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