



Supporting Patient Access Staff With an Interactive Scripting Solution

An nTelagent White Paper

www.ntelagent.com

nTelagent, Inc., 330 Mallory Station Road, Suite B-3, Franklin, TN 37067
615-866-0483
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Executive Summary

In her book *Understanding Patient Financial Services*, 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.

With these new responsibilities, the patient access department has been recognized as having a major impact on the efficiency of a healthcare provider’s revenue cycle. As a *Healthcare Financial Management Association* publication notes: “It is not far-fetched to call scheduling and registration processes the ‘face’ of a hospital’s 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. Yet for many years, the evolution of these patient access functions lagged behind that of other areas of the revenue cycle. Today, these circumstances have changed, as new developments in patient access are raising

this area to new levels--and giving hospitals the opportunity to present a new face to patients... 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.” (*Source: Patient access: A new face for the revenue cycle: patients' first impressions of hospitals are likely to improve dramatically as a result of recent breakthroughs in managing the revenue cycle's patient access processes, HFMA, March 2007*)

Recruiting, training and retaining the workforce 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. Healthcare providers are increasingly dealing with staffing issues in the patient access department, including high turnover rates, absenteeism and workload levels. **As the healthcare 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 solution 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 and accurate remittance at the point of registration. 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

A hospital in East Tennessee once had a sign in the lobby that read: “This hospital does not render service to collect money, but it must collect money to render service.” We have all heard the “no money, no mission” statements made by both for-profit and not-for-profit hospital leadership. While these notions are not new, the reality of collecting money to support health service providers has become increasingly complicated and more important than ever. Many healthcare providers are realizing the key to an effective revenue cycle strategy that will increase cash flow and reduce administrative denials begins at the patient access area. They also realize that the traditional patient access model needs to be updated.

Today’s patient access office executives, financial counselors and registrars are being asked to take on a variety of new tasks, often without effective tools and support in place. The patient access department has become a centralized information center with many functions traditionally performed in other locations. 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 often are not identified or handled appropriately and consistently. Patients can slip through without their personal information verified, and without any financial counseling or collections. When eligibility is not verified upfront, more patient claims can be denied, payments can be slowed, and more claims will need to be reworked. For the growing number of self-pay patients, specifically, the only opportunity for obtaining reimbursement of any kind is to collect cash at point of service.

There is frequently a failure to properly value admitting, scheduling and registration staff through appropriate pay levels and clear work guidelines. This leads to high staff turnover rates in patient access/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, indeed making the registration and admission areas the new

“face” of the revenue cycle. As the model has changed to more of a retail-based model, 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 (similar to a retail environment), all in the patient access area, including:

- Comprehensive pre-access data validation and sharing
- Comprehensive/coordinated patient financial and clinical processing
- Anticipation of resource consumption
- Application and resolution on encounter and process edits
- Record/demographic completion and resource consumption posting
- Managed care, care plan and financial monitoring

(Source: www.tricare.mil/conferences/2003/UBU-UBO/downloads/r202Keel.ppt)

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. To gauge the effectiveness of front-end processes and to improve patient access performance, an operational assessment is needed to determine current status and identify what is needed to take performance to the next level.” The article notes that best practice performance in patient access often leads to:

- Improved data quality
- Increased net revenue
- Improved productivity/performance
- Increased cash collections
- Reduced need to rework accounts on the back end due to errors or other shortcomings in front-end processes

(Source: *Patient access best practices: front-end processes are critical components of effective revenue cycle management, Healthcare Registration, December 2006*)

Clearly, improving patient access procedures can have a major impact on a provider’s bottom line. As noted earlier, however, there is frequently a failure to properly value patient access staff with appropriate pay levels and clear work guidelines. Best practice strategies to

improve revenue cycle performance can include patient access training, education and technology, and increased staff recognition/rewards.

The HFMA article mentioned before gives several examples of the intricate situations patient access staff deal with on a daily basis: “The complexity of the task facing this individual [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. Most

information systems are set up with too many plan choices for each carrier.

Meanwhile, the 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.”

Specifically, 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 all financial 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 healthcare service 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 provide registrars and financial counselors with interactive scripts that integrate patient demographic information with each provider's unique business rules, thereby eliminating the guesswork that goes along with determining a patient's financial responsibility. Having the ability to profile demographic data in determining how to pursue account collection and adjudication can help patient access staff more effectively manage financial accounts. **Coaching and scripting registrars and financial counselors can be powerful tools, saving a service provider time and money by helping staff avoid dangerous pitfalls and inconsistent and inefficient practices in patient access areas.**

Real-time scripting for registrars and financial counselors at the workstation expands individual responsibility and reduces levels of management unless the process is an exception to normal business rules. **As patient access staff's organizational structure and areas of**

responsibility continue to evolve, the information at their fingertips should do the same.

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

- Enable the patient access staff to consistently follow a provider's policies and procedures for collection of patient-due portions via online scripting
- Guide registrar in acceptable payment arrangements and discounts to be offered based on provider's policies and procedures
- Flag accounts where patients may qualify for charity or local, state or government assistance and guide registrar in steps that should be followed
- Verify patient's address and other critical information
- Increase upfront cash collections and reduce outsourcing costs by placing the policies and procedures to follow, and necessary tools, at the fingertips of the registrar
- Provide real-time reporting to monitor registrar performance, collections and compliance with policies and procedures

About nTelagent, Inc.

nTelagent, Inc. has developed The Retail Application for the healthcare industry, called the Self-Pay Management System (SPMS). Similar to applications used in the retail industry at the point of sale, the company's proprietary, automated system tells healthcare registrars and financial counselors exactly what to do and what to say to each patient at the point of service regarding financial responsibilities. Moving workflow to the front end of the revenue cycle, nTelagent helps providers ensure a better patient experience through clearer communication and better handling of patient accounts, while improving upfront and overall cash flow, receivables and profitability by reducing bad debt.

Using non-credit scoring data, SPMS provides interactive scripts that integrate patient demographic information with each provider's business policies and rules. The system allows for price transparency and automatically identifies discounting options, social services eligibility and charity care options when applicable, ensuring that patient financial accounting—for both insured and uninsured patients—is handled appropriately and consistently.

Visit www.ntelagent.com for more information.