Introduction to Patient Access Services

Patient Access Orientation Training Manual

National Association of Healthcare Access Management

Preface

Dear Patient Access Services Managers and Staff Development Instructors:

The National Association of Healthcare Access Managers (NAHAM) has developed this training manual for Healthcare Access Associates – your front-end staff. The information in this useful guide reviews a variety of topics essential in the orientation and development of front-end staff. It also can aid in the preparation of staff for the NAHAM Certified Healthcare Access Associate (CHAA) Examination.

This manual includes a course outline that may assist with course layout and preparation time. There is also a brief quiz at the end of each section.

Since this manual is distributed nationwide to large and small facilities and it is used in both the inpatient and outpatient arenas, the information is somewhat general. Therefore, there are opportunities for you to stress areas of particular importance to you or to add information specific to your healthcare organization or work location.

As the national organization that represents your interests and needs, NAHAM desires to support your efforts to developing and retaining quality staff. Your comments and suggestions regarding this training manual or any other issues are appreciated.

Sincerely,

The NAHAM Education Committee

About NAHAM

The National Association of Healthcare Access Management (NAHAM) is the only national professional organization dedicated to promoting excellence in the management of Patient Access Services in all areas of the healthcare delivery system. Patient access services professionals provide quality services in registration and all of its support processes to patients, providers and payers into, through and out of their healthcare experience.

NAHAM members have responsibilities for a wide spectrum of patient access services including, but not limited to, the following: Admissions, Registration, Financial Counseling, POS collections, Benefits verification, Pre-certification, Physician Relations, Guest Relations, Information, Telecommunications, Scheduling, and other related areas, such as Case Management.

Members may have evolving and specialized roles due to nursing and other training.

Members work in: Hospitals, including those dedicated to clinical specialties such as psychiatric, rehabilitation, children, women, and others, Nursing Homes, HMOs/PPOs, Freestanding Surgery Centers, Call Centers, Ambulatory Care Centers, Physician offices, Clinics, and Home Health Agencies.

Established in 1974, the Association serves as a central source of technical information on changes and trends in healthcare that affect admitting/registration processes and patient access functions.

With its national office in Washington, DC, NAHAM serves the national interests of its members by advocating progressive changes in admitting/registration procedures nationwide.

NAHAM is *the* source for valuable education and support on issues impacting Patient Access

Services. For more information, visit www.naham.org.

Table of Contents

SECTION ONE

Revenue Cycle Basics

A basic understanding of the Revenue Cycle provides the Patient Access staff with the knowledge of the critical role they play in the patient experience as well as in optimizing financial performance within their organization.

The Revenue Cycle consists of all of the administrative and clinical functions from a patient's first point of contact with a hospital until the account is resolved. These steps may include:

First Contact with a Patient is usually with a Patient Access Professional!

Patient Access

- Scheduling
- Pre-Registration
- Registration/Admissions
- Financial Counseling

Clinical Services

- Documentation
- Charge Capture

HIM / Medical Records

- Documentation
- Signatures
- Coding

Patient Financial Services / Billing

- Billing
- Collections and Follow-up
- Cash Posting
- Account Resolution

All of the functions within the Revenue Cycle are interdependent upon each other. Accuracy is critical to the success of the Revenue Cycle. It is important for all staff members to understand the significance and impact they each have on the patient's financial experience as well as the organization's financial health. In addition to understanding one's own personal role in the

Revenue Cycle, each staff member must collaborate with other individuals and departments to ensure that this complex interdependent system functions efficiently.

The Patient Experience is a significant driver in hospital Patient Satisfaction scores. Because these scores ultimately impact reimbursement, the Revenue Cycle as a whole must take into consideration the financial impact and possible inconvenience or burden that may be placed on the patient if steps within the Revenue Cycle are compromised. Patients have become responsible for a larger portion of their healthcare bills and it is important that communication of patient responsibility be done prior to or at the time of service whenever possible. The collection and communication of this information is often the work of Patient Access staff.

Once the patient has received services, other departments within the Revenue Cycle begin the work of charge capture, clinical documentation and complete and accurate coding. Since these back-end teams are not patient-facing, they rely on patient information entered into the system by Patient Access staff. Once coding is complete, the completed financially secured account is ready to be billed by a team within the Patient Accounts Department. Typically, healthcare facilities hold bills for a period of three to four days prior to submission for payment to allow for late charges to be added. Once the claim has been submitted to insurance, facilities generally expect payment from insurers within 45 days.

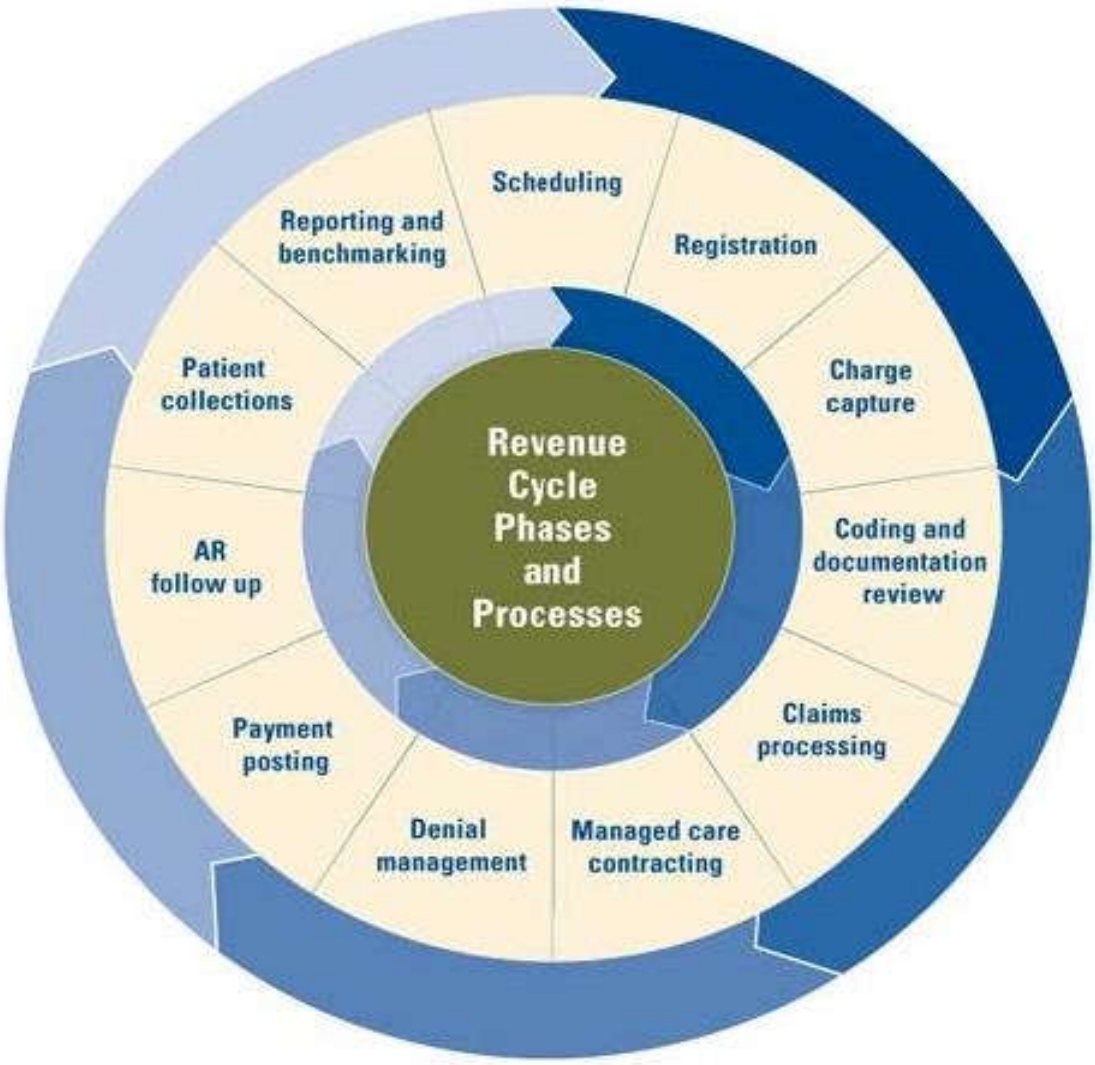
A number of key processes affect revenue and cash and result in rejected claims or denials from payers. They include incomplete insurance information, non-covered services and failure to identify medically unnecessary services, late charges, coding delays and discrepancies and untimely billing**.**

One of the most preventable reasons for claim rejections that delay collection of accounts receivable is inadequate and incorrect information gathered at the time of registration. During each interview, the Patient Access staff member should validate and update demographic and insurance information ensuring a clean claim can be generated by the Patient Accounting Department. Rejected claims extend the time in which payment is received and require re-work within the accounting department.

As patients become more involved in their healthcare and their healthcare finances, the Revenue Cycle must adapt a model similar to the retail industry. Healthcare consumers want healthcare that is convenient, seamless, personalized, transparent (in both quality and cost) and flexible. The hospital Revenue Cycle must keep up with industry standards and benchmarks to remain competitive in the healthcare markets.

Healthcare revenue cycle management involves many strategies, including procedures that hospitals and clinics use to improve cash collections and meet goals. These strategies also include customer receivables valuation, underpayment recovery policies and transactions involving federal government programs such as Medicare and Medicaid.

The Revenue Cycle



The Revenue Cycle includes all of the events that occur from the time a patient enters the healthcare system to the time the bill is paid or otherwise resolved.

Patient Access is at the beginning of the cycle. All other services depend on Patient Access for accurate and complete information from patient identification to entering insurance information to identifying financial needs.

SECTION ONE

Quiz

1. Patient Access is at the _____ of the revenue cycle.

    a. beginning
    b. middle
    c. end

2. Healthcare revenue cycle management consists of processes and methodologies that organizations put in place to ensure accurate and timely billing and payment of claims.

    True False

3. Other departments depend on the Patient Access Department for complete and accurate data.

    True False

4. All of the following could be the cause of insurance denials *except*:

    a. inaccurate insurance date
    b. incorrect patient identification
    c. non-covered services
    d. identification of medically unnecessary tests in advance of series

5. One of the most preventable reasons for claims rejection that delays collection of accounts receivables is:

    a. wait times
    b. incorrect information gathered at the time of registration
    c. failing to address a patient's special needs at point of registration

SECTION TWO

Patient Access Services Overview

Patient Access Services Department

Patient Access Services in a hospital setting encompasses many different roles and responsibilities. It is one of the most important and concentrated areas in healthcare.

It has been estimated that access staff is responsible for 80 cents of every dollar that comes into the facility. They are responsible for the delivery of the critical components of the Revenue Cycle, as well as keeping the hospital compliant with regulatory agencies, maintaining patient safety through correct patient identification practices and providing extraordinary customer service skills in situations that are often difficult.

The Patient Access Services model varies from facility to facility. In a large institution a Patient Access Associate may be responsible for a specialized type of patient registration or service in one particular are. By contrast, in a smaller facility, the Patient Access Associate may be responsible for several areas and multiple registration responsibilities. For example, a seven hundred bed hospital may have registrars in the Emergency Department who only register patients with an emergency encounter. In a rural fifteen bed facility, a registrar may register emergency patients, scheduled out patients, and in patients, while also being responsible for bed placement and serving as the hospital's PBX operator.

According to NAHAM, Patient Access general responsibilities include:

Customer Service

- Positive Identification of the patient
- Provide Information to the patient/family
- Help determine special needs of a patient
- Pre-admission services
- Scheduling of resources and services
- Pre-certification of insurance
- Determine the correct level of care
- Distribute and/or obtain signatures on required documents, such as the Consent for Medical Treatment, Privacy Notice, and Important Message from Medicare
- Infection Control
- Collection of accurate and complete patient information
- Point of Service collections

Some of the departments within Patient Access Services include:

- Registration: In patient, Outpatient, Emergency Department, Surgery areas, Clinics
- Pre-Registration
- Scheduling
- Insurance Verification and Pre-Certification/Referrals
- Information Desk
- Operator Services (PBX)
- Financial Counseling
- Patient Accommodations or Bed Control
- Pre-Service Clearance
- Master Person Index search database services

The Patient Access Services departments have a critical role in the overall success of a hospital. Most of the services performed in Patient Access are at the beginning of the Revenue Cycle.

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.

By obtaining accurate information at the point of registration, such as patient demographics and insurance or payment information, the services provided have a better chance of being paid in a timely manner and without penalties, which positively affects the overall cash flow and revenue of the hospital. Incorrect registrations are a major financial burden on any facility, especially when employees must allocate time to work denials, re-bill, credit balances, refunds, and reconcile incorrect reimbursements.

In a perfect world, the patient presents for service, their insurance company has already approved their service and has agreed to pay for it, the registrar collects accurate information and signatures, the service is performed, charges are entered correctly, the HIM department correctly codes the diagnosis and procedures, the bill is generated and sent to the provider and without any delays, payment is made. This is called a “clean claim.” Many departments and associates are involved in this process.

There are many possible obstacles that can delay or prevent reimbursement, as well as cause compliance and patient safety issues. Because Patient Access is often the patient’s first contact with the Revenue Cycle, Patient Access staff is on the front line to help prevent many of these errors.

Some challenges that face Patient Access personnel include:

- The patient may not be coherent to answer any questions; therefore the registrar may have to rely on family or friends for information or previous information.

- The patient may not have their insurance information available
- The patient may not be representing themselves truthfully.

Patient Access Services Overview

Basic Job Roles

Patient Access Associates have to wear many different hats at any given moment. They must be proficient in a multitude of areas, since everything a Patient Access Service Associate does affects patients, families, other associates, and the viability of the organization. Any one mistake may cause a patient safety issue, a legal issue, a customer service issue or a revenue issue. A Patient Access associate must take every function seriously and provide service with 100% accuracy.

Basics include:

- Being proficient with the hospital registration and ancillary computer systems. A registrar may need to know upwards of 9-15 different systems to perform job functions. Job functions include how to register the patient, how to verify insurance, how to check eligibility, how to check medical necessity, how to scan and retrieve documents in the imaging system and how to take payments and print receipts.
- Knowing which rules, forms and questions must be applied to specific encounter types and insurances to ensure the facility remains compliant with government agencies and regulations.

Examples include:

  - Health Insurance Portability and Accountability Act (HIPAA)
  - Emergency Medical Treatment and Active Labor Act (EMTALA)
  - Consent for Treatment (General Consent)
  - Patient Rights and Responsibilities
  - Medicare Important Message Notice of Privacy Practices
  - Medicare Secondary Payer Questionnaire (MSPQ)

Patient Access is also responsible for:

- Knowing insurance basics such as identifying commercial and government plans, understanding coordination of benefits and recognizing when to obtain a referral, authorization or waiver.
- Being able to give continually excellent customer service in adverse situations. Healthcare customer service skills must include empathy and compassion.
- Understanding and knowing how to discuss financial information and obligations and know how and when to refer to others for help.

Here are just a couple of every day scenarios in the life of a Patient Access Representative:

Scenario A:

Upon arrival, the patient is identified. This is most often performed by the registrar but can also be the RN or triage. If the patient is new to the system, both a medical record number and encounter number will need to be created. If the patient has been seen previously and already has a medical record number, the registrar will need to locate or create the encounter number. Always avoid creating duplicate medical record numbers. The medical record includes all of the patient's health and demographic information for the facility. The encounter number is used for documentation, orders and charges related to a specific service or stay. A patient should only have one medical record number, but can have dozens or even hundreds of encounter numbers, depending on how many visits or appointments the patient has had with the healthcare facility.

Working with the patient or patient's family when possible, the registrar must:

- Obtain correct demographic and emergency contact information.
- Note the reason for the encounter and whether or not it was due to an accident.
- Identify the correct guarantor for the visit.
- Obtain the patient's insurance or payment information.
- Accurately load the insurance plan, the networks, the mailing address and phone numbers, the identification numbers, the subscriber of the policy along with their SSN, DOB, address and employer for every policy the patient carries.
- If there are multiple insurance policies, know how to prioritize these policies for payment.
- Determine and collect copays, as applicable for the visit.
- Input the correct attending, admitting, referring and family physician.
- Obtain signatures for treatment and the release of information form, as well as any other forms required for the visit.
- Give the patient the Patient Rights form and the Notice of Patient Privacy information

How would this change if the patient was unconscious?

Scenario B:

The patient presents to the registrar's desk to register for an add-on CT scan. The patient has lung cancer and this test will determine whether or not the cancer has spread to the brain which would account for the patient's recent loss of vision and headaches. The patient has been at this facility recently, so much of the demographic and insurance information is available from a previous visit which makes the registration fairly easy. However, the physician failed to sign the order for the CT scan, which means a new one must be obtained before the patient can have the service. The test wasn't ordered STAT and the patient's insurance plan requires an authorization for today's CT scan. Since it wasn't obtained in advance the registrar must present the patient a waiver of financial liability to inform the patient that they will be financially responsible for the $2000 procedure today. The patient begins to cry because they don't have the money. They haven't worked for 5 months due to their illness. Now what?

Scenario C:

A physician schedules 84 year old Mrs. Smith for a procedure she can't pronounce. She doesn't drive much since her husband passed away last year and she has several concerns:

- How to get there?
- What time is her appointment?
- Where should she park?
- Does she need to bring her insurance cards?
- Will she need money?

The registrar in the pre-registration department calls Mrs. Smith to get all of her paperwork prepared in advance of her appointment. She confirms Mrs. Smith's appointment time, gives her detailed information on where to park and what to expect once she arrives. Mrs. Smith is no longer anxious and feels confident about her upcoming visit to the hospital.

In most situations the registrar is one of the first people that a patient or family member comes in contact with at the hospital. Whether it's on the phone scheduling them or discussing their upcoming visit, registering them for their service, escorting them to a bed, another department or to their family member, Patient Access Associates are responsible for setting the tone for the patient's visit. A Patient Access Associate must possess extraordinary customer service skills. We will discuss this in more detail in the Customer Service section of the book.

Patient Access Services Functions

Scope of Responsibility

The Patient Access Associate provides quality services in registration, scheduling and all of its support processes to patients, providers and payers throughout the patient's healthcare experience. The associate is responsible for timely, accurate and courteous registration of each patient prior to the delivery of care. The Patient Access Department provides services to supply the foundation for medical records, billing and collections.

Components of Registration

Positive Identification of the Patient

Prior to the onset of registration, the Patient Access Associate should utilize their facility's search criteria to determine the presence of an existing medical record number (MRN). Typically the search options consist of numeric, phonetic or a combination of both data. To ensure the patient's identity, a government issued photo identification such as driver's license, military ID or passport should be requested and scanned into your facility's document imaging system. Consistent with The Joint Commission's safety goal, two identifiers must be utilized to ensure positive identification of patients prior to the delivery of care.

The primary identifiers would include:

- Correct spelling of names
- Use of legal names
- Date of Birth
- Social Security Number
- Previous names (e.g. maiden or married)

Secondary identifiers include:

- Address
- Gender
- Telephone number

Selecting a wrong patient can lead to many issues regarding treatment and payment but the most critical issue is that of patient safety.

Every patient should have only one record. This "medical record" should be the repository for all patient documentation while at the hospital. Included in the medical record is their physician orders, test results, documentation of service and forms.

Failure to use proper search techniques may lead to a Duplicate Medical Record Number (one patient with two or more medical records). Duplicate records are a patient safety issue and considered a significant registration error.

The Health Information Management (HIM) department is responsible for maintaining each patient's medical record as part of the Master Patient Index.

Patient Access is typically responsible for the creation of the medical record number (MRN) for patients who are new to the organization/provider. They must also locate a patient's previous number for each visit so that today's information can be combined with all other medical information kept on that patient.

Ethnicity

Data collection during patient interviews is a critical component of Patient Access. In addition to validating demographic and insurance information, other mandated fields are captured during patient registration.

Many states require hospitals to collect and report data on race, ethnicity and language. This data provides a better understanding of the community they serve and helps to match their workforce to communities they serve. Ethnicity and race information is also used for grant applications, to target quality of care initiatives, and for contractual compliance obligations with government contracts, particularly Medicare and Medicaid. Additionally, ethnicity and race information helps clinical staff to determine patient risks for developing certain diseases or conditions based on risk factors for a particular ethnicity or race.

The Patient Access professional should approach the topic of race and ethnicity with sensitivity. Healthcare facilities should develop standard scripting for Patient Access staff to use when collecting this information.

Sample Scripting for Obtaining Ethnicity and Race:

'We are required by law to collect information regarding the race and ethnicity of our patients. Of the following choices, what best describes your ethnicity?'
'Hispanic or Latino origin or Non-Hispanic or Latino '

'Of the following choices, what defines your race?'

- *American Indian/Alaskan Native*
- *Asian*
- *Black/African-American*
- *Native Hawaiian/Other Pacific Islander*
- *White*

References: US Census Bureau- Statistical Standards: Defining Race and Ethnicity

Race is based in the following five categorizations:

- American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

- Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" can be used in addition to "Black or African American."
- Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Conducting the Interview

The Patient Access Associate creates the initial record that serves as the foundation of the patient's medical record. The data collected is utilized by multiple members of the healthcare team to include Patient Accounts, Patient Information, Clinicians and Health Information Management. A complete interview must be conducted with the patient or responsible party to ensure the most current and accurate data is on file. The collection of demographic and insurance information along with other required registration fields must be validated and updated each time a patient is registered.

While each organization may have a unique computer system for the collection of information required on each patient, following is a list of data commonly collected:

- Patient's Address and Phone Numbers
- Patient's Date of Birth
- Patient's Social Security Number
- Patient's Primary Language
- Patient's Employer Information
- Ethnicity/Race
- Emergency Contact Information
- Religion and Church Affiliation
- Entering the patient's reason for the visit via accident codes (auto, work, etc.)
- Guarantor and Subscriber Information
- Insurance Information
- Medicare Secondary Payer Questionnaire
- Attending, Primary and Referring Physician

In addition, other entries required by a facility may include:

- Email address
- Previous Names
- Advance Directives
- Allergies
- Communicable Disease

An Access Associate should utilize solid interview techniques by ‘questioning’ the patient and avoiding ‘read back’ validation practices.

Interview Tips

ASK!

Solicit information from the patient. For example:

- What is your address?
- What is your marital status?
- May I list your religion or do you have a specific church affiliation you would like me to add to your record?

Do not engage in ‘Read back’ interview techniques.

Do not read information from registration screens and ask the patient if it is correct.

- High risk for identity theft
- Potential disclosure of PHI
- Too many inaccuracies
- Returned mail
- Rejected claims

Collection of Insurance Information

A registrar is responsible for the input of the patients insurance or payment information. A registrar must be able to recognize the many different types of insurance plans and then input the correct numbers, addresses and phone numbers. More information about insurance is available in section three.

Patient Access staff need to be familiar with many types of insurance, including:

Government Plans

- Medicare
- Medicare Advantage
- Medicaid
- Medicaid HMOs
- Tricare/Champus
- State Child Health Plan
- Indian Health Services

Commercial Plans

- Anthem
- Blue Cross
- United Healthcare
- Cigna
- Aetna
- And many more

Self-Pay or Liability

- Discount programs
- Charity
- Auto Insurance
- Worker's Compensation
- No Fault

Depending on the facility, registrars also may need to know which insurance plans require:

- Waivers of financial responsibility (contracted vs. non-contracted payers)
- Referrals
- Authorizations

Subscriber Data Collection

The subscriber is the person who "owns" the insurance policy. If the insurance is through an employer group, the subscriber refers to the person whose employment makes him or her eligible for group health insurance benefits. When interviewing the patient, it is important to ask who the insurance policyholder is in order to determine the subscriber. Many times, this information can also be verified by using an online tool.

Guidelines for Determining Policyholder

The policyholder (or subscriber) is the person who contracts with the insurance company for healthcare coverage. The policyholder may or may not be the person whose name appears on the card. To determine the policyholder, use the following guidelines:

- For most Blue Cross, Commercial, and PPO (Preferred Provider Organization) insurance, the policyholder is the person whose name appears on the insurance card.
- Most HMOs (Health Maintenance Organization) give each insured person his or her own card. In this instance the person on the card may be the patient, but the patient may not be the policyholder. You will need to ask who the policyholder is on the insurance.
- For most HMOs the policyholder can be identified by a two-digit suffix of 01. Spouses are usually identified by a suffix of 02, and dependents with 03, 04 and so forth.
- For Tricare (formerly known as Champus/ChampVA) insurance the policyholder will be the sponsor or the person who is active or retired from the military.
- For Medicare, Medicaid, and Workers Compensation, the policyholder will ALWAYS be the patient.

Guarantor Data Collection

The guarantor is the person or entity who is financially responsible for payment on a patient's account. Usually the patient is financially responsible for medical charges. A parent or legal guardian/trustee is the guarantor for patient's under 18 years of age. This may also be the case for patients with a decreased mental capacity.

If the patient is under 18 and legally emancipated, then the minor patient can be listed as the guarantor. Legal emancipation can be achieved by:

- Court order
- Pregnant or custody of a child
- Married before the age of 18
- Graduated high school before the age of 18

The guarantor listed on the registration is the person who will receive all notifications referencing a claim to include the insurance EOB's and billing statements.

Point of Service Collections

Many hospitals require Patient Access Associates to collect co-pays and deductibles at the time of service. This will require the registrar to have knowledge of pricing or pricing software as well as money management skills.

Many patients appreciate knowing in advance of service what their portion of the bill will be. This gives them time to prepare or to work out arrangements for payment.

Registrars who either collect or discuss payments with patients must be knowledgeable about out of pocket expenses.

Out of Pocket Maximum

The Out of Pocket Maximum is the total payments toward eligible expenses that a covered person funds for him/herself and/or dependents. These expenses may include deductibles, co-pays, and co-insurance as defined by the contract. Once this limit is reached, benefits may increase to 100% for health services received during the rest of that calendar or policy year. Deductibles may or may not be included in out-of-pocket limits.

Deductible

A deductible is the amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will begin to pay for eligible benefits.

Co-payment

Co-payment is a payment that must be made by a covered person at the time of service. Services that require co-pay, and the predetermined amount payable for each service, are specified in the policy. Co-payments may be required for physician visits.

Co-Insurance

A co-insurance is a set percentage amount that a patient must pay based on the total amount of charges for a visit. Depending on the plan, a patient may have different co-insurance amounts for different services (e.g. specialist vs. emergency visits).

Calculating Patient Liability

Steps to Calculate Patient Liability – Managed Care

See next page

CALCULATING INSURANCE PAYMENT AND PATIENT LIABILITY

MANAGED CARE

Step	Process Description	Formula	
1	Estimated TOTAL CHARGES based on resources provided by facility. Total charges are needed *IF* the insurance contract reimburses based on charges		(A)
2	Determine CONTRACTUAL DISCOUNT for type of service provided	(Per Contract)	(B)
	- Percent of charges		
	- Per diem		
	- DRG		
	- Fixed Rate or Case Rate		
3	Calculate TOTAL CONTRACT FAYMENT AMOUNT by subtracting contractual discount from total charges *or* enter the CONTRACT PAYMENT AMOUNT for the DRG, Per diem, Fixed Rate, etc.	(A-B) or (B) for fixed payment amount	(C)
4	Determine unmet DEDUCTIBLE amount based on insurance verification		(D)
5	Calculate TOTAL CONTRACT FAYMENT DUE LESS DEDUCTIBLE	(C-D)	(E)
6	Determine patient COINSURANCE RATE based on insurance verification		(F)
7	Calculate patient's COINSURANCE AMOUNT	(E x F)	(G)
8	Calculate TOTAL PATIENT LIABILITY *cannot exceed remaining OOP maximum*	(D + G)	(H)
9	Calculate TOTAL INSURANCE PAYMENT	(E x (100-F))	(I)
10	VERIFY ACCURACY	(H + I)	= C

Note - the TOTAL PATIENT LIABILITY cannot exceed the patient's maximum out of pocket amount

EXAMPLE # 1:

Total Charges $400

The patient's insurance has a contract with your facility that reimburses based on a percentage off of the total charges. The contract allows for a 25% contractual discount.

Insurance Verification indicates $100 unmet deductible and 10% coinsurance. Maximum OOP = $1,500 not including the deductible

Step	Process Description		
1	TOTAL CHARGES		400.00
2	CONTRACTUAL DISCOUNT	(400 x 25%)	100.00
3	CONTRACT RATE	(400 - 100)	300.00
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(300 - 100)	200.00
7	COINSURANCE AMOUNT	(200 x 10%)	20.00
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(100 + 20)	120.00
9	TOTAL INSURANCE PAYMENT	(200 x 90%)	180.00
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(120 + 180)	300.00

Note - the TOTAL PATIENT LIABILITY does not exceed the patient's maximum out of pocket amount. The patient owes an estimated amount of $120.00 for this visit.

EXAMPLE # 2:

Total Charges $8,000

Per diem contract with 4 day length of stay at $1,250 per day rate

Insurance Verification indicates $1,000 unmet deductible and 20% coinsurance. Maximum OOP = $2,000 not including the deductible

Step	Process Description		
1	TOTAL CHARGES		N/A
2	CONTRACTUAL DISCOUNT		N/A
3	CONTRACT RATE ($1,250 per day x 4 days)	(1,250 x 4)	5,000.00
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(5,000 - 1,000)	4,000.00
7	COINSURANCE AMOUNT	(4,000 x 20%)	800.00
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(1,000 + 800)	1,800.00
9	TOTAL INSURANCE PAYMENT	(4,000 x 80%)	3,200.00
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(1,800 + 3,200)	5,000.00

Note - in this example, the TOTAL CHARGES are not applicable because the contract reimburses based on a per diem amount

The TOTAL PATIENT LIABILITY does not exceed the patient's maximum out of pocket amount. The patient owes an estimated amount of $1,800 for this visit.

EXAMPLE # 3:

Total Charges $27,645

Insurance contract rate -- DRG rate for the procedure $8,293.50

Insurance Verification indicates $363 unmet deductible ($500 deductible -- $137 already met) and 20% coinsurance. Maximum OOP = $1,500 *including* the deductible

Step	Process Description		
1	TOTAL CHARGES		N/A
2	CONTRACTUAL DISCOUNT		N/A
3	CONTRACT RATE	Fixed Rate for the procedure	8,293.50
5	TOTAL CONTRACT PAYMENT DUE LESS DEDUCTIBLE	(8,293.50 - 363)	7,930.50
7	COINSURANCE AMOUNT	(7,930.50 x 15%)	1,189.58
8	TOTAL PATIENT LIABILITY (Deductible + Co-insurance) *cannot exceed OOP maximum*	(1,189.58 + 363.00)	1,552.58
9	TOTAL INSURANCE PAYMENT	(7,930.50 x 85%)	6,740.92
10	VERIFY ACCURACY (Patient Liability + Insurance Payment = Total Contract Rate)	(1,152.58 + 6740.92)	7,930.50

?

** Because the patient's maximum out of pocket is $1,500 *including* the deductible, the estimated amount due cannot exceed $1,500 **
The error was identified after "verifying accuracy" because the amounts did not equal.

To correct the calculation:
$1,500.00 is the maximum out of pocket *including* the deductible
- 137.00 is the amount of prior expense applied to the OOP max
$1,364.00 is the remaining OOP maximum

The patient owes an estimated amount of $1,364.00 for this visit.

CALCULATION ERROR
Note - the TOTAL PATIENT LIABILITY exceeds the patient's maximum out of pocket amount of $1,500

In addition to calculating the estimated amount due for the current or upcoming visit, patient access employees should also review previous balances to determine if the patient has any liability. If the patient / guarantor owes for a previous account or accounts, the balance(s) should be requested during the process of collecting the current estimate.