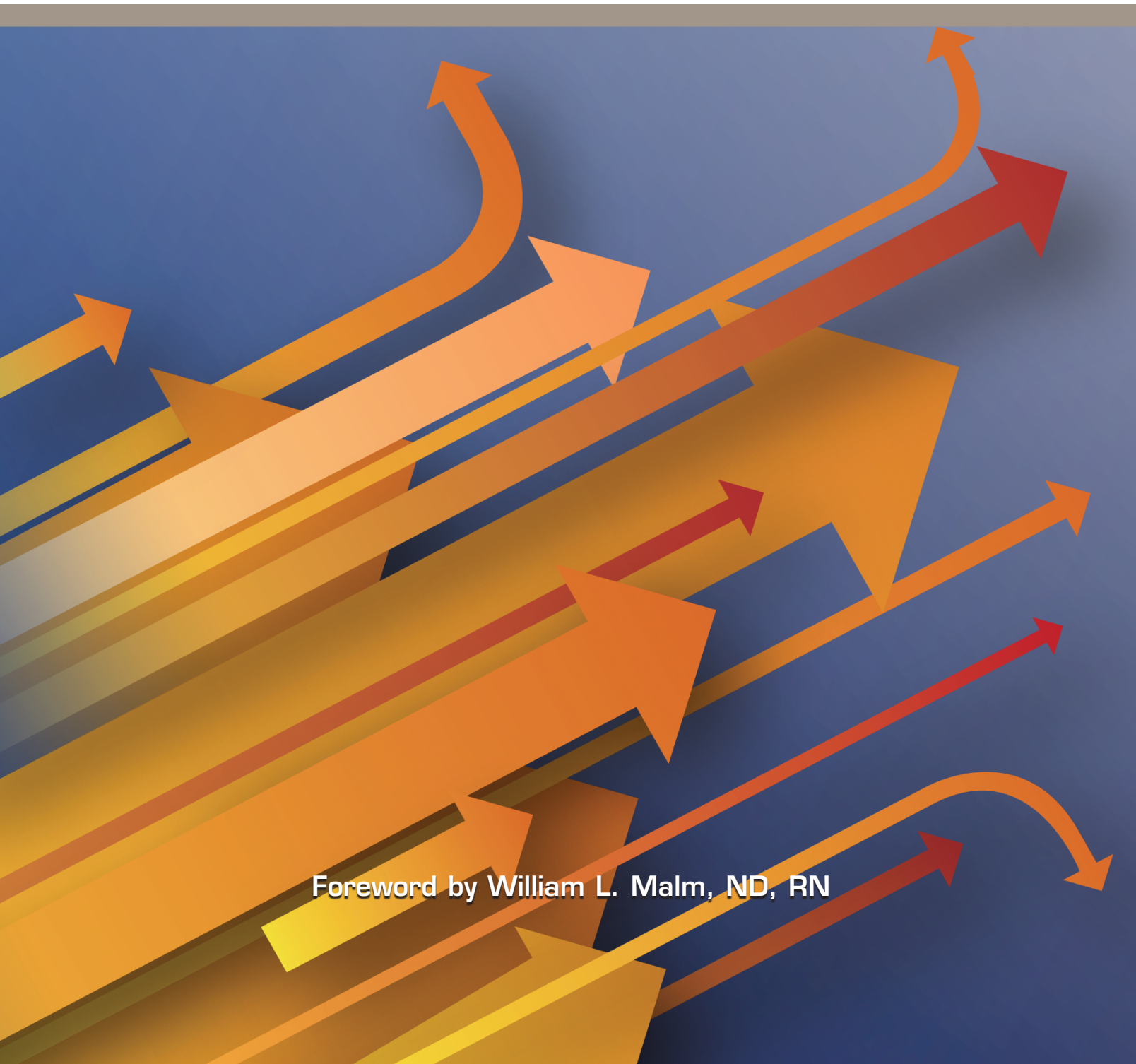
Revenue Cycle Management Toolkit

A Comprehensive Guide to Managing Cash Flow



Foreword by William L. Malm, ND, RN

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HCPro

Revenue Cycle Management Toolkit: A Comprehensive Guide to Managing Cash Flow is published by HCPro, Inc.

5 4 3 2 1

ISBN: 978-1-60146-210-7

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6/2008
21454

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About the Contributing Editor

William L. Malm, ND, RN is the practice director for revenue cycle management consulting and the Revenue Cycle Institute within the consulting division at HCPro, Inc. He has more than 20 years of experience in a combination of clinical and financial healthcare management roles, serving as a compliance officer, revenue cycle specialist, and chargemaster specialist.

Having performed more than 100 chargemaster analyses, Malm's expertise is in the resulting operations, including education, audit, and post-implementation reviews. In addition, he has acted as a compliance officer and director of revenue integrity for several facilities, and has specialized in revenue cycle corrective-action plans and implementations at mid-sized hospitals.

The Revenue Cycle Institute is designed to create successful strategies to confront and manage today's challenging reimbursement and compliance concerns. The Institute encompasses all aspects of patient access, charge capture, coding, billing, reimbursement, and denial management with a focus on regulatory oversight and compliance.

For more information call 877/233-8734 or email *revenuecyclemanagement@hcpro.com*

Foreword

The evolution of the revenue cycle continues to present facilities, physicians, and other healthcare delivery systems with challenges. The Centers for Medicare & Medicaid Services (CMS) updates regulatory guidance frequently, causing constant turmoil within the operations of the healthcare facility or office. Only with a thorough understanding of the reality of the revenue cycle can you take an aggressive approach toward successfully integrating the guidelines, anticipating the changes (whenever possible), efficiently adapting to those changes, and arriving at sustainable processes for success.

The revenue cycle is best described as the component pieces of a large jigsaw puzzle known as healthcare delivery. Many of these pieces fit, while others never seem to be quite right. To be successful, all the pieces must fit within the organization and its culture, using the resources available. Every facility must inventory the tasks along the patient flow and document flow continuum to ensure that it is seamless. In the first chapter of this book, you will examine a case study from the University of North Carolina, at Chapel Hill, that details a plan for success.

Too often, in my practice, I find that each department within the revenue cycle operates as if it were an island. The communication among departments is often fragmented or nonproductive. Many times, words are used interchangeably and mean different things to different departments, adding to the confusion. Ultimately, at its worst, communication can translate as finger-pointing and serve only to disrupt progress. Effective communication is critical to a successful program and is a fundamental goal of many of the programs and tactics mentioned in this book.

Baseline education as part of any undertaking is also essential to ensuring all parties are on "the same page." Patient access plays a critical role in ensuring that a "clean claim" is submitted. The importance of the Medicare Secondary Payer (MSP) process becomes more important than ever before. Even more daunting is ensuring the accuracy of the MSP—a failure can result in a recovery audit contractor (RAC) finding and a recoupment of improper MSP payments. In other words, the front-end process can determine the success or failure of the overall integrity of the earned revenue.

After these functions are completed, there are other pitfalls ahead in the documentation, coding, and chargemaster functions. Errors in the chargemaster from retaining deleted procedure codes, inappropriate modifier applications, and current procedural terminology codes that do not represent what is in the patient medical record can be construed as a "false claim." Current CMS initiatives show that coding and charging correctly are more important than ever before. The RAC findings provide examples of incorrect numbers of units for billed pharmaceuticals based on the order and medication administration record. Billing errors occur daily, and processes should be in place not only concurrently but for retrospective analysis as well.

To confront these concerns there must be sustainable daily processes. Many of these processes are recommended in the collection of articles and tools contained within this book, addressing all phases of the revenue cycle: patient access, coding and chargemaster, billing, and auditing. Specific recommendations are offered under the steps outlined for successful emergency department (ED) management of the revenue cycle. Some of the scenarios and issues presented are ones that your organization can identify with; others may not be as familiar, but dedication to the process and a commitment to success are a recurring theme throughout. The case studies, tips, and expert advice presented here should assist any revenue cycle manager in becoming savvier in dealing with the revenue cycle and honing his or her ability to design and implement sustainable, cutting-edge processes.

Chapter 1

UNCHCS Case Studies

CASE STUDY

UNCHCS turns adversity into significant process improvement initiative

Editor's note: The following is the first in a four-part series that examines the significant patient financial process changes UNC Health Care has undertaken.

Accepting criticism is an unpleasant responsibility for any organization. But adversity can be an excellent opportunity to initiate change that emphasizes the hospital's commitment to excellence and loyalty to the community it serves.

The University of North Carolina Health Care System (UNCHCS) found itself in such a situation in the summer of 2006 when newspaper articles and community feedback highlighted deficiencies in the system's delivery of care.

Specifically, the reports grilled UNCHCS for what others perceived to be questionable collection practices, unreasonable payment plans, and miscommunications with patients regarding financial assistance options.

"Not all the reports were 100% accurate," says **Hunter Wagstaff,** UNCHCS' director of healthcare system accounting. "But people were questioning whether we were following our mission." Because UNCHCS is a state agency, it must follow certain statutes in terms of its collection policies, but at the same time remain a safety net for those who are unable to pay their hospital bills.

"The comments that were made focused attention on specific areas we already wanted to improve," Wagstaff says. "The [criticism] just accelerated the process for us."

A team effort

UNCHCS, which is based in Chapel Hill, cares for approximately 400,000 patients per year in a multihospital system with more than a dozen community-based practices spread out over six counties.

Refining processes for so many patients at so many different facilities was a challenge for UNCHCS administrators.

UNCHCS CEO **Dr. William L. Roper** spearheaded the initiative with input from legislators in the state's general assembly, citizens in the local community, and the president and chancellor of the university system.

The administrators surveyed the patient population for concerns it had with the system. The group compiled the list and used it as a framework to develop six teams of healthcare staff,

CASE STUDY

UNCHCS turns adversity into significant process improvement initiative (cont.)

which the group commissioned to observe processes over several months and report back with suggestions for change. Each team had a leader and anywhere from two to six team members.

Team 1

Administration assigned the first team to observe communications with patients. They focused on whether staff knew what the financial policies were and whether they helped patients understand them.

"They also looked at the language barrier," Wagstaff says. "We have lots of Spanish-speaking patients in this area, so they wanted to see if we needed more bilingual staff."

Team 2

The second team set out to determine ways that patients could access financial assistance more efficiently. This was an important task, as solutions directly affect the uninsured patient. It also directly affects the reimbursement the health system can reasonably expect.

"They looked at everything from hiring more financial counselors to working closely with the Orange County Department of Social Services," says Wagstaff.

About 25% of UNCHCS' patients are on Medicaid or are uninsured. "This meant a lot of work with the state and county [to facilitate change]," he adds.

Team 3

Administration assigned the third team to look at the health system's discharge procedures. It's an important safety and customer service responsibility that administration hoped to revamp.

"We want to make sure we're doing the best job we can with postdischarge care, making sure [patients] received cared here and got home in a safe manner," Wagstaff says. "This was a big job because it crosses various departments in the hospital. But it was important to ensure that we're all working together as one."

Team 4

The fourth team looked at collection policies, specifically innovative ways to streamline the financial assistance, billing, and appointment processes.

"This was one of the bigger groups because [it] tried to incorporate so many different areas to improve the patient experience while they are at the hospital. They also tried to improve throughput so staff can move patients around easier," says Wagstaff.

CASE STUDY

UNCHCS turns adversity into significant process improvement initiative (cont.)

The team focused attention on ways to schedule appointments faster, while looking at reminder notices.

Additionally, the team identified strategies to review large claims to determine whether the patient was eligible for any type of financial assistance.

Team 5

The fifth team monitored changes and reported results. "Basically, the team used data to support ongoing self-assessment and improvements," says Wagstaff.

That includes setting up an audit process for charity care applications, tracking availability of bilingual Medicaid assistance counselors, and tracking the numbers of patients approved for financial assistance.

The team has also started using mystery shoppers to determine whether patients are happy with their experience, says Wagstaff.

Team 6

The final team set out to increase community participation. This task had two major initiatives.

First, the team added a community representative to the board of representatives to serve as a voice for the patient population.

Second, it considered adding community membership to an internal group called the Financial Assistance Oversight Committee, which will monitor policies and procedures. However, this group discusses technical issues, so the team hasn't decided whether community membership is necessary.

Report cards

All six teams reported their findings in January. Some of the teams' recommendations were already in the pipeline, and others are on the way. The adversity that the health system faced last year only forced it to slam on the gas pedal.

"I think everybody here knew we needed to make some changes, but getting there was a struggle," says Wagstaff. "It took some effort, but I'm happy that we made the effort."

CASE STUDY

UNCHCS increases access, improves financial assistance for patients

Editor's note: The following article is the second in a four-part series examining the significant patient financial process changes the University of North Carolina Health Care System (UNCHCS) in Chapel Hill has undertaken.

Long before newspaper articles and a community petition called into question UNCHCS' mission as a state agency, officials identified the system's financial assistance program as an area that needed a major overhaul.

It was only after receiving negative feedback that UNCHCS looked more closely at its program and decided that it needed a better strategy to address both the community's concerns and its troubling trend of lost revenue.

"We were providing about $500,000 a day in uncompensated care, and $185 million a year for our entire system," says **Karen McCall,** UNCHCS' vice president of public affairs and marketing. "We knew we couldn't continue to do this, and we decided to really trim our costs, increase our volume, and still be able to make a decent bottom line."

Back to the drawing board

UNCHCS' first run at the problem was met with harsh criticism. In 2005, UNCHCS officials agreed that asking people directly for bill collections wasn't the best approach. Instead, like many hospitals, UNCHCS developed a charity care program for its most needy patients.

The program includes a 25% discount for anyone who is uninsured. UNCHCS also extended its financial assistance eligibility criteria from 200% of the federal poverty guideline to 250%.

UNCHCS' charity guidelines took effect in January 2006. In coordination with the new guidelines, UNCHCS registrars made a concerted effort to collect money at the point of service.

"But the community hated it. They thought that we were betraying our mission," McCall says. "They didn't pay attention to the financial assistance; they wouldn't even come if they had to pay up front." Making matters worse was the fact that a state law requires UNCHCS to work with the attorney general's office to collect any debt greater than $1,000.

"The community believed we were targeting them unfairly because of their inability to pay their bills and, in some cases, taking them to court over that bill as one of the collectors of the debt," says McCall.

CASE STUDY

UNCHCS increases access, improves financial assistance for patients (cont.)

The community voiced its opinion formally through a petition, and UNCHCS had to tear down its program and build it back up again.

Second time's the charm

In retrospect, the firestorm of criticism helped the healthcare system understand how to balance both its own fiscal needs and those of its 700,000-patient population. UNCHCS' first priority was obtaining financial counseling and adding to its financial team.

At the time, the system employed about 20 financial counselors. It added five in fall 2006, and its managers immediately went to work training the counselors. "That wasn't easy. This is a fairly complex plan," says McCall. For starters, the managers covered everything that Medicare deems medically necessary.

"But there are always exceptions with major procedures, so making sure all of these financial counselors understood these exceptions was a great challenge," McCall says. Additionally, managers changed the phone scripting to include information about UNCHCS' new financial assistance program. "We also provided more information about this at the point of service," says McCall. UNCHCS officials also spread the word through local newspaper ads.

The new financial counselors began working full-time in January. Since then, McCall says the community response has been terrific. "A lot of people are now coming to us for financial assistance," she says. "We are definitely learning that folks have found out about it and like it."

Sharing the patient population

Next, UNCHCS looked at its long lines and capacity concerns. As a long-term solution, UNCHCS is working to increase its number of beds. But in the short term, the system set out to team with a local primary care health system to divert some of its nonemergent cases there.

Piedmont Health Systems has clinics throughout Chapel Hill, but it didn't want to risk hiring more primary care physicians without the assurance that more patients would be headed their way.

UNCHCS identified through its case managers the repeat offenders—those patients who use the UNCHCS emergency department for noncritical care. "We're just trying to coordinate the care of the uninsured," McCall says.

CASE STUDY

UNCHCS increases access, improves financial assistance for patients (cont.)

UNCHCS and Piedmont drafted a letter of agreement in December 2006, and soon the two systems will work together to improve the quality of care for both of their patient populations.

Referrals a real focal point

The lines of communication didn't exist for smooth referrals to UNCHCS from community health centers. UNCHCS officials realized the need to develop protocols for referrals from Piedmont and other health entities to UNCHCS subspecialists and ancillary providers. The biggest problem, UNCHCS officials learned, was that each UNCHCS department handled referrals differently; there wasn't a uniform policy within the system.

Part of the problem was that 50% of Piedmont's patients are uninsured. So some UNCHCS clinics avoided seeing these patients because they were trying to make ends meet and knew they wouldn't get paid for the care.

"We had to educate them that, from a health system point of view, this is a good thing," McCall says. "We assured them that if a particular department is taking a majority of referrals for something like trauma or orthopedics, the health system, as a whole, would take care of them."

CASE STUDY

UNCHCS improves financial assistance communications

Editor's note: The following article is the third in a four-part series examining the significant patient financial process changes that the University of North Carolina Health Care System (UNCHCS) in Chapel Hill has undertaken.

Your organization has done its homework. It has surveyed the patient population, identified areas for improvement, drawn up plans to initiate wholesale change, or huddled to tweak existing processes. But your work isn't done. If any of your customers are unaware of the changes you've made or unsure of how to take advantage of them, your work will be for naught.

UNCHCS officials have responded to public criticism—questioning its mission as a state agency—with an overhaul of its PFS operation. The organization's work hasn't gone unnoticed, as UNCHCS has dedicated time and resources into projecting the message of the patient-friendly changes out into the community.

Telephone reminders

Patients who schedule appointments at UNCHCS receive a reminder call with an automated telephone message from the facility. The messages remind patients to bring their insurance cards and copays with them at the time of their appointment.

However, UNCHCS revised its messages to inform patients that financial assistance is available and how to inquire about this service. Revising the phone message recordings was a chore. UNCHCS found that there was a different telephone message for patients at every clinic. UNCHCS has more than 500 individual clinics, which handle about 800,000 visits each year.

"We had to fix about 400 messages," says **Karen McCall,** UNCHCS' vice president of public affairs and marketing. Further, McCall feared that patients would construe the tone of the original messages as aggressive. "They all talked about money, so pretty much, all you'd hear was, 'Bring money, bring money, bring money,' " McCall says. "That's not what we wanted to say."

Awareness of assistance policies

In 2005, UNCHCS first introduced an automatic discount. Uninsured patients received an automatic 25% discount. UNCHCS handled this discount on the back end; the system didn't require patients to apply.

"We announced this in a press release, but I don't think a lot of people were aware of it, because we didn't need any interaction with the patient to accomplish it," she says.

CASE STUDY

UNCHCS improves financial assistance communications (cont.)

In January 2006, UNCHCS extended its financial assistance program to those at 250% of the federal poverty guidelines.

Again, UNCHCS was relatively quiet about the lenient eligibility requirements. "There was concern that if we made too big a deal about it, we'd be overwhelmed," says McCall. "So, we did it low-key, and though there was some pickup in the numbers, we didn't notice it much."

UNCHCS officials became more proactive—first with telephone messages, then with signs in every clinic and a charity care telephone helpline. The signs now appear in both English and Spanish to accommodate the large spanish-speaking population.

"We also trained our clerks to do a quick look at the [patients' financial information] and the federal poverty guidelines to give them a rough idea of whether they'd qualify for assistance," she says.

Proactive assistance

Many patients do not understand how financial assistance works, and when and if they should apply. UNCHCS officials realized how important it is to educate patients about this option early in the process.

To accomplish this, UNCHCS officials trained staff members in each clinic to offer financial counseling to every patient.

"We want to encourage [the patients] to ask questions, so it was important to train clinic staff to interact better with them," says McCall. "Patients should know the different areas they may need to contact, such as our Medicaid counselors."

Awareness of payment plans

Additionally, UNCHCS offers patients the ability to enroll in a no-interest payment plan. Officials want the facility's financial counselors to make sure that all patients who come through their doors know that this is a potential option for them.

But both sides also need to hammer out the details of the payment plan, and preferably before the back end is sending out statement after statement. UNCHCS' policy is for payment plans not to exceed 36 months.

CASE STUDY

UNCHCS improves financial assistance communications (cont.)

"We just have a limited ability to track these," McCall says. "Our collections people are good at collecting money from insurance companies. But it's hard developing that expertise when our patient payment amount is about 10% of all of our money."

UNCHCS communicates the different options up front. In some instances, UNCHCS sets patients up with collection agencies that offer longer payment plans. "Even if the patient has had bad debt before, we're trying very hard to talk to them about consolidating that debt and finding a payment plan that works for them," she says.

Financial assistance telephone hotline

UNCHCS officials strongly believed that many of its patients who needed financial assistance the most were unaware of this option.

So early in 2007, they decided to create a hotline for patients to call with their questions from 7 a.m.–9 p.m. UNCHCS trained call center staff members to complete the first quick fix, which is to determine whether the patient may qualify for assistance. If they do qualify, the call center staff members transfer the patient to a financial counselor.

UNCHCS officials have placed advertisements in local newspapers, publicizing this feature and plastering the facility's phone number wherever they can, including on bill statements.
The response so far has been good, says McCall. "We've since gotten a number of people in the program."

CASE STUDY

UNCHCS simplifies financial assistance, processes

Editor's note: The following is the final article in a four-part series examining the significant patient financial process changes that UNC Health Care System (UNCHCS) in Chapel Hill, NC, has undertaken.

As a finance professional within your organization, you understand that your biggest priority is—and will always be—your bottom line. But hospital administrators everywhere now see a direct connection between customer service and the organization's financial well-being.

The challenge is being creative and smart enough to identify what process changes will make life easier on your patient population, and how to transform ideas on paper into real-life solutions. "That's the difficult part," explains **Karen McCall,** UNCHCS' vice president of public affairs and marketing. "You need a team approach to really make things happen."

When newspaper articles and a community petition challenged UNCHCS' commitment to its customers in 2006, officials targeted the financial assistance program as an area that could use a tune-up. "We went back to the drawing board," McCall says. "We talked about a lot of different areas and what we could do to improve."

Financial assistance application

First, UNCHCS officials looked at the system's financial assistance application form. Immediately, they could see that it was too long, difficult to read, and duplicative. "We decided to start from scratch and work with our patients to make the form simpler, easier to read, bigger, and much shorter," says McCall.

When officials looked even closer, they realized that they were duplicating many of the same processes involved with the Medicaid application. The questions on the form were often confusing for patients and staff members, and the result was a number of denials that officials didn't originally attribute to the long-winded form.

UNCHCS has since cut the updated form in half to about two pages. The facility unveiled the form in February, and officials say they have seen a sharp increase in the number of approved applications.

"That's the outcome we were looking for, and we're very happy about that," says McCall. The customer service response, both internally and externally, has all been positive. "Everyone agrees that this is a much easier form for patients to fill out and staff to understand," McCall says.

CASE STUDY

UNCHCS simplifies financial assistance, processes (cont.)

Appointment management

UNCHCS officials also identified scheduling problems in many of the system's clinics. Upon inspection, officials noticed that there was a high rate of wasted appointments when patients didn't show or schedulers didn't properly follow up with patients to resolve scheduling issues. Further, schedulers didn't necessarily consider the supply and demand of each clinic in order to more effectively distribute patients.

UNCHCS' new Patient Access and Clinical Efficiency (PACE) program works with individual clinics to manage the scheduling process. "What we've done is try to match the supply of providers with the demand of clinic spots," says McCall. "Basically, we're listening more to the [patients] when they say they can't make an appointment, and we're actively trying to accommodate them."

In the past, the clinics would schedule appointments based solely on the providers' availability. UNCHCS has documented an 8.9% increase in the number of successful appointments since the fall of 2006. "We think that's a really great start," McCall says.

Customer service department education

UNCHCS officials also realized that their customer service departments were not adept at answering billing questions that applied to both UNCHCS and UNC Physicians & Associates. UNCHCS developed a new curriculum to train everyone and make the process uniform across its 60 clinics. "We standardized everything, and in some cases, included scripting for them," says McCall. "Each department had their own slight interpretation, so it was important for patients to receive the same information, no matter where they entered the system."

Duplicate collection processes

UNCHCS officials also wanted to reduce any duplication in the collections process. Many of the clinics use different collection agencies. "We wanted to avoid multiple people approaching the same patients," says McCall. "The physician group can't have a different story than the hospital." UNCHCS coordinates catastrophic care. But different vendors were looking at the same accounts and presenting the patients with different messages.

"We are now making sure that all the letters sound the same and that we are working together all the time," she says. "The physician bill is different than the hospital bill, and everyone must know that."

FOLLOW-UP

UNCHCS monitors initiative progress, reports results

Editor's note: This is a follow-up to the four-part series on the significant patient financial process changes that the University of North Carolina Health Care System (UNCHCS) in Chapel Hill, NC, made in 2007.

In 2007, officials at UNCHCS thoroughly examined every financial process. They considered customer service, financial viability, and staff burden, and they drew up realistic changes that would keep each of the system's priority interests in mind.

In many cases, they tore down the process structure and put up new walls from scratch. When they completed their entire process redesign, all that was left was a strategy to monitor progress and report results, says **Karen McCall**, UNCHCS' vice president of public affairs and marketing. "It was important for us as a system to [track our performance]," she says.

Instituting audits for charity applications

Officials made whole-scale changes to the manner in which the system screened patients for eligibility, assisted patients in the process, and alerted patients of the charity care program. But the changes were no good if UNCHCS couldn't determine whether the new program worked.

UNCHCS designed and instituted an audit process for all charity care applications and began tracking the number of patients UNCHCS approved for financial assistance every quarter. Almost immediately, UNCHCS recorded a 20% increase in the number of applications patients filled out. "It was a definite and noticeable increase for us," says McCall. "It told us the process was working."

Assessing the availability of bilingual Medicaid assistance counselors

To further the system's efforts to reach out to the community's bilingual population, UNCHCS is working with nine community-based practices and their bilingual counselors to ensure that Spanish-speaking families have the same access to financial counseling as English-speaking families.

This is another process that has seen tremendous results. "Our Medicaid applications are now way up," McCall says. "We haven't gotten our Medicaid approvals up much, but our applications are definitely up. And that's a definite win for the system." UNCHCS has also begun to use mystery shoppers to test access to financial assistance.

FOLLOW-UP

UNCHCS monitors initiative progress, reports results (cont.)

Letting five principles shape the change

UNCHCS is monitoring progress but also emphasizing to staff members the following key principles that evolved from the process redesigns:

1. **Exhaust all third-party options to cover the cost of care.** At the end of fiscal year 2006, UNCHCS had a staggering $290 million bottled up in accounts receivable. Now, prompt payments are the order of the day.

   "Our charity care program is only available when all other options are exhausted. We had to clarify that," McCall says. "Things weren't consistent in our system. So much of this process was just being diligent to get consistency throughout the system."

2. **Ensure access to financial counselors.** In 2006, UNCHCS expanded eligibility requirements for its charity care program. However, at the time, it didn't bulk up its staff to accommodate the additional business.

   "Without sufficient staff, we really weren't able to keep our promise," says McCall. So UNCHCS added five financial counselors to the staff. The organization also uses roving financial counselors, who bounce around from clinic to clinic, going wherever there is a need. Clerical staff members order a roving financial counselor through a program on UNCHCS' Web site.

3. **Ensure that billing is accurate and easy to read.** This is probably the biggest challenge for UNCHCS.

   "I think we'll keep working on this the rest of our lives," McCall says. "Hospital and physician billing is so complex that this will always be a challenge."

   UNCHCS relies on customer focus groups to shape new ideas to simplify the bills. "People are still looking for a MasterCard bill, and it's just not that easy," says McCall. "I think the industry as a whole still has a long way to go."

4. **Ensure that patients understand their obligation to pay.** One ongoing challenge is the fact that hospital-based clinics have an opportunity to charge a facility fee in addition to the physician charge.

   This is because Medicare and Medicaid recognize that large institutions have additional costs, because they provide a level of testing to which a normal physician office doesn't

FOLLOW-UP

UNCHCS monitors initiative progress, reports results (cont.)

have access. However, educating patients as to why they're receiving two bills isn't easy. "We've really given a great deal of effort to make sure the patient doesn't find this out as a surprise," McCall says. "We send letters to them ahead of time, and we include a notice on the appointment slips to alert them to this."

The notices also serve as a valuable tool in the customer-friendly collections efforts. "Patients are more than willing to pay; they just don't want to deal with our billing system," says McCall.

5. **Assist patients with payment plans.** UNCHCS has enlisted the assistance of its collection agencies to offer no-interest loans.

   "It just makes more sense to do what it takes to get our principle paid back," says McCall. "Before, we could only allow patients to pay us over 36 months. Now, if they need longer, we can make arrangements."

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