Reducing Patient No-Shows

Reminder phone calls are critical, whether personal or automated.

BY LYNN HOMISAK, PRT

To Our Readers: *There are no foolish questions. Chances are that if you have a question or concern in your practice, others are experiencing a similar situation. We're here to help. PM [doctor and staff] readers are encouraged to submit questions to lynn@soshms.com which will be printed and answered in this column anonymously.*

Re: Automated or Personal

Dear Lynn, We recently had a verbal scuffle here in our office about whether or not to continue calling patients personally to remind them of their appointments or go to an automated system. The doctors are the ones who need a little convincing. Do you lean one way or the other?

Let's hear comments from both camps—first, from those who feel making personal calls is the more favorable way of handling appointment reminders; and secondly, from those who find that using an automated system is the way to go.

Personal:

- Patients prefer the "personal touch", appreciate speaking to a human as opposed to a "robocall." Without question, this is the most common complaint about automation.
- "Patients hang up on automated systems." "They don't like them." "It's not good customer service."
- Staff can communicate specific instructions to patients, e.g., "don't forget your paperwork, orthotics, medications, insurance cards, copays", etc.
- Staff can remind patients to bring any past due balances with them.
- Changes are received in "real time", so if a patient wants to reschedule an appointment, it can be done right then and there. This actually saves time.
- "An automated system is too confusing to learn and will upset our routine."
- "We like doing things the way we're doing them now. It works for us."

Apparently, patients don't seem to mind automation after all.

Automated:

- It saves time overall. Depending on the number of patients seen in the practice, it can save staff one to two hours/day in actually making the calls and conversing with patients who ask questions unrelated to their appointment.
- One to two hours/day of staff time is easily measured and can be extremely productive doing other tasks.
- With many systems, staff have the ability to record their own voices, so patients still feel a sense of personal connection.
- Because the automated call instructs patients to confirm whether or not they plan to keep their appointment, staff can receive immediate verification and only need to follow up with those patients who need to reschedule.
- Produces reports on appointment confirmation.
- Makes several attempts to reach patients if at first they don't succeed.
- Staff can cherry-pick which patients would need to be called for special instructions and/or reminders (e.g., new, surgical, and critical patients.) Some claim the senior population finds it hard to adapt to automation; however, in today's world, that is rapidly changing. Just ask them.
- Phones (and staff) are not tied up with "how's the weather" chitchat.

With regard to patients preferring the personal touch, the one question you need to ask yourself is, what percentage of "personal" calls actually result in staff leaving a message on patients' answering machines? Not surprisingly, the range is 50% and higher! So, with those kinds of percentages, who's automating who? Apparently, patients don't seem to mind automation after all.

If you recall, similar reasoning

Continued on page 62

No-Shows *(from page 61)*

was used when switching from answering services to a recorded message. Who doesn't have voice messaging these days? Patients and doctors adapted quickly, realizing that voice mail is efficient and convenient. It gets the job done.

Reminder phone calls are critical, whether personal or automated. Statistics show they reduce patient no-shows by 30%, so doing them is an improvement over not doing them.

Front desk personnel need to be trained in consistently securing accurate patient data with not only new, but also inactive and existing patients.

Since you asked (and you may have already put this together), efficiency levels increase time after time. With some exceptions, patients do get used to them—many, (surprise!), even make a point of saying they like it! Good customer service does not have to die with the decision to automate. Hopefully, seeing both sides will shed some light on which is best for your practice.

Re: Show Me the Money?

Dear Lynn, Lately, we have had way too many claim denials. I'm not exactly sure why this is happening, but it is impacting our cash flow. What kinds of pre-emptive steps should we be taking in order to get claims paid the first time, ON time?

Depending on the insurance company, a clean claim might get paid in seven days, whereas a denied claim can take anywhere from six to eight weeks or longer. Below are several common reasons. ALL of them are fixable, provided you have the right person handling your billing and a good system put in place.

- Errors and missing data in patient registration—Front desk personnel need to be trained in consistently securing accurate patient data with not only new, but also inactive and existing patients. Insurance information changes all too often, so copy the front AND back of insurance cards for your own protection. For those patients who are seen routinely, staff should at least ask to see the card to compare it (again, front and back) with what's in their record. Relying on patients to automatically provide insurance updates results in old, useless data and ultimately, a denial. Since they are not always quick to offer new info up, it falls on the front desk to ask. When doing so, it's better to replace, "has anything changed with your insurance?" with, "Mr. Banks, I will need to see your insurance card to double-check that everything is still the same."
- Lack of insurance verification—Yes, this takes time, but it has proven to be time well spent when you consider the risk of not getting paid for treating someone whose insurance coverage has expired. Insurance verification can mostly be done online—but if you really want to get benefits info at the same time (particularly for new patients and orthotic/AFO benefits), a call is more effective.

Continued on page 63

No-Shows (from page 62)

Remember, it's wise to delegate such time-consuming tasks to the lowest paid staff person who can get the task done right. Use a standardized form for consistency and preferred outcomes.

• Incorrect coding—Staff should not be kept in a bubble when it comes to educating them about coding processes and techniques. In addition to sending them to billing and podiatry-specific coding seminars, give them sufficient tools and resources, e.g., online resources, such as Codingline—www.codingline.com/ and APMA Coding Resource Center—www.apmacodingrc.org/, webinars, and up-to-date coding reference manuals. Having an educated billing staff means keeping them in the know with proper codes and modifiers, bundling of services and contractual rules so that they can proactively double check a claim for accuracy, and make necessary input and/or changes before it gets submitted.

• Review EOBs and monitor write-offs carefully—Even though the billing responsibility may fall in the laps of certain staff, it is always wise for doctors to review their EOBs and EOMBs for errors that are not initially caught. Is the insurance company justified in saying a certain procedure is being denied as part of the primary procedure, when in fact, it is a separately identifiable service? And is staff writing this off because the insurance company said so? Are appeals being initiated in these cases? Don't feel that double-checking EOBs borders on micromanagement. It is, in fact, an opportunity to educate staff and make them aware of potential repeat scenarios.

Some companies may not allow claims with attachments to be filed electronically, so inquire as to what the best method is to get this information to them.

• Insufficient documentation to process claim—Whether it is a lack of required pre-authorization, the need for medical necessity documentation, mandatory referrals, or insufficient clinical/surgical info, any one (or all) of these are reason enough for an insurance company to hold up or reject payment of your claim. If orthotic claims, for example, are repeatedly being returned because medical necessity is required, save yourself a step (and another denial) by making it a point to always include this documentation, proactively, with the original claim. Some companies may not allow claims with attachments to be filed electronically, so inquire as to what the best method is to get this information to them. It sure beats waiting for the expected denial, then waiting again for a second claim to be processed through the system.

When doctors remain disconnected from their billing operations, the results are unapproved short cuts, inefficiencies, errors, no reporting or monitoring, lack of follow-through, and disappointing A/R numbers. Granted, while doctors should be focused on the clinical (as opposed to the administrative) aspect of their practice, a certain involvement is necessary to: 1) ensure that proper coding is being submitted, 2) optimum reimbursement is received for their services, 3) proper appeals are initiated, 4) insurance companies are kept in check and responsible for agreed upon and contracted fee schedules, and 5) all monies passing through the practice are documented and accounted for.

Do you want a collections check list to help keep your billing office primed for success? Email me: lynn@soshms.com. **PM**

Ms. Lynn Homisak, President of SOS Healthcare Management Solutions, has a Certificate in Human Resource Studies from Cornell University School of Industry and Labor Relations. She is the 2010 recipient of *Podiatry Management*'s Lifetime Achievement Award and inducted into the PM Hall of Fame. She is also an Editorial Advisor for *Podiatry Management* Magazine and recognized nationwide as a speaker, writer, and expert in staff and human resource management.