DISTANCE LEARNING COURSE

Overview of a Patient Encounter
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OVERVIEW

The patient experience in an ophthalmic practice is illustrated in this module. Beginning with telephone interactions and appointment making with patients, the processes utilized by the practice to prepare for the patient encounter are described. Also included in the discussion is an introduction to patient check-in, patient flow through the office, check-out, and billing and collection policies.

TELEPHONE SKILLS

The patient encounter most frequently begins with a telephone call to the practice. In this initial contact, it only takes about 15 seconds for a patient to form either a positive or negative opinion of the practice; therefore, the person answering the phone is vital in creating positive impressions. From this point on, everyone who comes in contact with the patient has an opportunity, a moment of truth, to make the patient experience a positive one.

Throughout all telephone communications, the goal is to portray a positive image. This can be done by utilizing the following effective telephone communication techniques:

1. Answer the phone as quickly as possible (before the third ring).
2. When answering the phone, always:
   - Confirm who the patient is calling: “Dr. ______’s office.”
   - Confirm who is the patient speaking with: “This is Mary.”
   - Invoke a response: “How may I help you?”
3. Smile when answering the phone (callers can “hear” your smile).
4. Identify who the caller is and use the caller’s name.
5. Listen to the caller, acknowledging requests or concerns.
6. Treat every caller as though they were speaking to a friend.
7. Stay positive.
8. Transfer calls by letting the caller know they are being transferred and to whom.
9. When transferring a call within the office, inform the staff member who will receive the call what the caller is asking about, so the caller does not have to repeat himself/herself.
10. Ask the caller for permission to be put on hold, wait for permission, and return to the caller as soon as possible. Express appreciation for holding.
11. Apologize for errors or delays.
12. Take messages correctly, confirming the name (including proper spelling) and phone number. Mark messages with date (day, month, year), time of call, and the initials of the person taking the message.

Each office has its own guidelines for answering the telephone. Please check with your orientation coordinator for specific protocols.
TRIAGING TELEPHONE CALLS

When a patient calls the practice, the person receiving the call must be able to ascertain the patient’s needs and provide appropriate triage. Remember the patient may be under stress, so it is important to remain courteous and professional while attempting to obtain sufficient information.

Reasons patients call the office:

1. **Appointments.** If the patient wishes to schedule an appointment, it is vital to determine the reason for the visit. If the problem is urgent in nature, it is important to schedule the appointment in a timely manner with the proper physician.

   Often the patient’s insurance will determine which physician can see the patient; therefore, confirming the insurance coverage of the patient is critical. For example, if the patient is coming to the office for a routine vision exam and is going to use their vision care plan, the patient might be scheduled with an optometrist. If the patient is coming for a medical problem, the visit may be scheduled with either the optometrist or the ophthalmologist, depending on the patient’s insurance. It is also important to determine whether the patient needs authorization from his or her insurance company to be seen. Most patients appreciate reminders when authorizations are needed.

   Appointments are recorded either by computer or by the use of handwritten appointment schedules. Computerized scheduling offers the advantage of efficient integration with billing and medical record processes. When scheduling the appointment, it is critical to obtain the following information:

   - Nature of the problem.
   - Name of the patient with correct spelling.
   - Address (for billing and recall purposes).
   - Telephone number (needed to confirm appointments).
   - Date of birth of the patient.
   - Social security number.
   - Insurance information.

   Appointment scheduling can require complex decision making (i.e., when to schedule the patient, expected length of visit, which physician can see the patient, how long will it take to obtain an authorization, etc.). Each office determines a schedule that will work for practice efficiency, so it is important to follow practice guidelines. Some visits will require more time than other visits, and a balance of different types of visits is attempted to eliminate long waits for patients once they arrive for their appointment.

   **Appointment Scheduling Tips:**

   **EMERGENCIES REQUIRING SAME-DAY VISITS**

   | Sudden loss of vision with or without pain. | Binocular double vision. |
   | Severe head or eye pain/sensitivity to light. | Problems from surgery in less than one month. |
   | Floaters AND flashes. | Trauma where the globe has been disrupted or penetrated. |
   | Foreign body or corneal abrasion in the eye. | Severe blunt trauma-forceful blow. |
   | Chemical burns or toxic substances in the eye. | Acute rapid onset of pain or discomfort. |
   | Eye irritation or discharge. | Emergency referral from another MD or OD. |
SITUATIONS REQUIRING PATIENT TO BE SEEN 24-48 HOURS AFTER CONTACTING THE OFFICE

- Sub-acute loss of vision that has evolved gradually over a period of a few days to a week.
- Red eye without discharge.
- Blunt trauma - eye is bumped - penetration of the globe is not likely.
- Double vision that is persistent for less than a week.
- Photophobia - sensitivity to light.
- Progressively worsening ocular pain.
- Loss or breakage of glasses or contact lenses needed for work.

When the following conditions have been present for several weeks or more, schedule the next available routine appointment. If symptoms worsen, instruct the patient to call the office.

- Discomfort after prolonged use of eyes.
- Difficulty with near work or fine print.
- Mild eye irritation, itching, burning.
- Tearing in absence of other symptoms.
- Lid twitching or fluttering.
- Mucous discharge from eye.
- Mild redness of the eye(s) not accompanied by other symptoms.
- Persistent or unchanged floaters whose cause has already been determined.

2. **Questions regarding medications, treatment, contact lenses, billing, etc.** When messages are taken, staff members obtain information regarding the nature of the question, as well as the patient’s name (verify correct spelling) and phone number. Patients are told that a staff member will pull the patient’s medical record and return their call before the end of the day. If the question is more urgent in nature, the staff member will pull the medical chart and return the patient’s call promptly. It is important to remember HIPAA privacy regulations when sharing a patient’s medical information with the caller. Attention to this detail is very important so that private information is shared only with those who are allowed access to the information. Check your office’s HIPAA Privacy Practices for specific protocols for your practice.

**PREPARATION FOR THE PATIENT’S APPOINTMENT**

Once a patient is scheduled for an appointment, the work of the staff is just beginning. Charts must be prepared in advance to facilitate the registration process for patients. If the patient is an established patient, the chart will be retrieved from the file storage area, chart work-up sheets attached, and pertinent information brought forward in the chart. New charts are prepared for those patients who will be coming for their initial visit to the office.

**Encounter forms, or superbills,** are attached to each chart. These forms are used to record service/procedure codes (CPT Codes) and diagnosis codes (ICD-9-CM) applicable to the specific patient encounter. The person preparing charts will check to see if authorizations are needed for the visit and make appropriate calls to facilitate the authorizations. Schedules for the following day are printed and distributed as needed throughout the office, and charts for each patient scheduled for the following day should be at the front desk in preparation for the patient’s visit so the patient can move smoothly through the office system.

**DAY OF THE APPOINTMENT**

1. **Patient Registration (Check-In)**

   *Welcome.* Patients should be warmly welcomed by the receptionist. A smile, eye contact, and addressing patients by name are important in setting the tone of the patient encounter.
Registration Forms. Upon arrival of the patient, the receptionist will identify whether a patient is new or established, determining the need for completion of registration and insurance verification information.

New Patients: A standardized registration form is used for new patients, which includes information such as full name, address, employer, insurance coverage, emergency notification, and method of referral to the practice. The emergency notification is often useful in subsequent collection efforts, while referral information can provide helpful marketing data. In addition, most new patients are asked to complete a medical history form at this time, listing pre-existing conditions, health concerns, and general observations. Proof of insurance coverage is also requested, usually in the form of a card issued by the payer, and coverage should be confirmed by telephone, if necessary. Any consent forms (HIPAA, authorization to file insurance, etc.) or waivers needed by the practice should be explained to the patient and a patient signature obtained. At this time, the patient should be informed of payment terms including any co-payments required by the payer.

Established Patients: The receptionist will review basic registration information (including insurance information) with established patients to ensure accurate, current records. If such information has changed, the receptionist can either update the records or invite the patient to complete a new registration form. Copies of new insurance cards should be made. Returning patients may be asked to update their medical history at least yearly.

Insurance. The provisions of insurance coverage are important to clarify, especially if pre-authorizations or co-payments are required by the payer (insurance company). If service is provided without preauthorization, the payer may refuse coverage and the payer contract may preclude billing the patient for such services. Registration staff should be well versed in such matters and able to advise patients regarding the application of insurance coverage to anticipated services.

Other Registration Responsibilities for Staff

- Registration information is entered into the computer. This may be done immediately upon patient registration or batched with other new patient registrations for end-of-day entry.
- Hardcopies of the registration form, history, insurance verification, and various consents are filed in the chart, and the encounter form (superbill) is attached to the chart.
- The chart, with attached encounter form, is forwarded to a technician or physician who is ready to begin the medical portion of the patient encounter. This process should remain simple to prevent misplacement during the transfer of charts.

2. Patient Examination

Once the registration process is complete, the patient is ready to begin the medical exam. Usually a technician will greet the patient and begin the initial testing needed in preparation for the physician’s exam. This process is explained in detail in another module, “The Anatomy of the Patient Exam.”

3. Documentation of the Patient Encounter

At the end of the patient exam, the encounter form is completed by the provider or designee. The procedures performed and the appropriate diagnoses for the patient are listed on the encounter form.

Many eye procedures share the same name but differ in definition (i.e., a simple description such as “office visit” fails to differentiate between a brief, five-minute visit or a comprehensive, one-hour visit). Procedures that have more than one name can cause further confusion. Standardization and consistency have been achieved through use of a common structure that assigns numeric codes to all procedures performed by providers. This system, copyrighted by the American Medical Association, is known as “Current Procedure Terminology,” or CPT. These numeric codes are used by virtually all insurers to identify medical procedures provided by physicians.
Medicare Basics

In similar fashion, diagnoses are also assigned numeric codes. The standard diagnosis codes used in medicine today are taken from the “International Classification of Diseases, 9th Revision, Clinical Modification,” commonly referred to as the ICD-9 or the ICD-9-CM. This system lists virtually every diagnosis, allowing providers and payers to effectively communicate the nature of the patient’s condition.

In most practices, the provider personally records the diagnosis and procedural codes on the encounter form. If someone else is responsible for completion of the form, they must be familiar with diagnostic and procedural coding, ensuring appropriate cross-referencing of such data. Insufficient codes can lead to payer rejections.

The completed encounter form and chart are forwarded to the front desk for processing and filing.

4. Patient Check-Out

At the conclusion of the patient encounter, each patient should stop at the check-out desk. The check-out clerk will note the total amount of the day’s charge and any outstanding account balance. The clerk will then verify whether the patient should make a payment on the account. If the patient has insurance, the check-out clerk should inquire whether the patient has met their deductible, and request payment for any amounts not payable by the insurer. Payment should also be requested if the patient is uninsured or responsible for a co-payment.

In addition, the check-out clerk reviews registration information with the patient to ensure accuracy. Encounter forms are also reviewed to ensure appropriate procedural and diagnostic coding. Original copies are provided to the patient, while copies are forwarded to the appropriate staff member for data processing.

During the check-out process, the clerk will either schedule a return appointment or place the patient appropriately within the patient recall schedule. Most computer systems offer some form of recall module allowing the practice to maintain patient mailing lists and prepare reminder cards for future physician services needed by the patient. This is an easy and cost-effective method for in-house marketing.

Check-out staff has the final opportunity in the patient encounter to build a positive relationship with the patient. As noted previously, smiling, giving eye contact, and calling the patient by name is important to let the person know they are valued as patients. Check-out should never become a routine or rote process; rather, this stage of the patient encounter should be used to the practice’s full advantage.

AFTER THE APPOINTMENT

After the patient leaves the office, there is still work to be done to finalize the encounter. The appointment schedule is compared to the encounter forms to ensure each patient encounter during the day was recorded in the computer. The encounter forms, accompanied by the day’s schedule are forwarded to data processing staff, who enter the results of the day’s transactions into the computer.

Upon completion of the service provided, the billing office will typically prepare a billing statement in either hard copy or electronic form. This statement is then transmitted to the patient and any applicable payer.

BILLING PROCEDURES

Encounter Form

As previously noted, the encounter form (superbill) is the source document for patient charges. The completed superbill shows the amount charged for services that day, includes previous amounts due, allows for notation of payments made that day, and provides a total of the net amount due.

For smaller practices, this method provides a simple way to bill patients at the time of service, while simultaneously providing a form that can be used by the patient for insurance submission. At the same
time, it serves as a comprehensive, immediate receipt for patients who pay at the time of service. Superbills usually have three parts or more, with one copy used as an encounter form and retained for practice records, another copy provided for the patient’s records, and a third copy utilized by the patient as a receipt or forwarded by the patient to their insurer.

**Claims Submission**

All patient and treatment information must be accurate and complete when submitting statements for payment. The billing format must be compatible with payer requirements, as well as HIPAA security and privacy standards. Ensuring these elements are adhered to minimizes payment turnaround and facilitates payment of accounts.

Over the past several years, billing processes have become largely automated, primarily due to electronic filing requirements of Medicare and other payers. As a result, nearly all current billing software includes capability for submission of electronic claims. Paperless transmittal can greatly increase the speed of insurer payments while reducing the chances of misplaced claims.

Hardcopy statements are necessary for direct patient billing and for those payers that do not accept electronic claims. Statements are normally divided into different categories, based on the type of payer and/or billing requirements involved. For many practices, the following categories are used:

- Private Pay (Patients)
- Medicare
- Public Assistance/Medicaid
- Commercial Insurance
- Workers’ Compensation
- Managed Care

This categorization allows the practice to maximize the efficiency of billing and collections efforts. For purposes of accounts receivable management, these categories allow specific monitoring of payment types, helping to identify trends and problems in collections.

**Billing Frequency**

Efficient billing office procedures require statements to be processed and distributed evenly throughout the month. Although smaller practices may find a single monthly billing to be more efficient, most practices process several billings throughout the month, called “cycle billings.” Unless unusual circumstances dictate otherwise, patients with outstanding accounts will receive a statement from the practice once per month. If services were provided during the month, the statement summarizes the nature of those services and the charges involved. If no services were provided in the month, the statement indicates the status of amounts payable by the patient (i.e., 30 days past due, 60 days past due, etc.) and includes any payments received on account during the prior billing period. If the practice applies finance charges to outstanding amounts, these are included on the statement as well.

**PAYMENT PROCESSING**

Accurate and timely processing of payments is a critical function for any practice. Processing requires immediate receipt or endorsement, accurate posting to practice records, and secure deposit in the practice bank account. Depending on practice size, these tasks may be assumed by one person or may be distributed among many. Regardless of task distribution, all individuals responsible for payment processing must understand its importance and have a clear understanding of all components related to the process.
Payments may be received in a number of ways, including personal check or cash at time of service, personal check by mail, payer check by mail, or electronic remittance deposited directly into the practice bank account.

Payments received from patients, whether in person or by mail, should be recorded by issuance of a receipt, with the receipt copy used for recording the payment on the patient’s account. The checks should be immediately endorsed upon receipt and secured for deposit later in the day.

Payer remittances, whether paper or electronic, will usually encompass a number of patients and services within a single payment transaction. Payer remittances are normally accompanied by an explanation of benefits (EOB) that identifies the patients and services covered by the remittance. These payments are posted to the appropriate patient account.

ACCOUNTS RECEIVABLE

The balance due on services rendered by the practice is known as accounts receivable (AR). Practice success in managing accounts receivable is largely based on the effectiveness of its policies and procedures. A variety of individuals share responsibility for the effective collection of accounts receivable – the practice administrator, the front office staff, the check-out and billing staff, and the physicians or persons completing the encounter forms (superbills). Proper follow-up must occur at appropriate intervals.

Staff members assigned to collection duties should be pleasant, persistent, perceptive, organized, and unintimidated by confrontation. Properly administered collection processes are essential to the success of accounts receivable management. These processes should also be implemented with understanding of the Federal Debt Collection Practices Act (FDCPAA). This is a law designed to eliminate abusive tactics used by third-party collectors and outlines restrictions to follow in contacting persons with outstanding bills.

CONCLUSION

As you can see, there are many different facets to the patient encounter. By understanding the various components and their interaction with each other, you will be able to contribute a smooth functioning and positive experience for the patient.
Medicare Basics

COURSE EXAMINATION

1. In most cases, the practice’s initial encounter with the patient is:
   a. Upon arrival at the office.
   b. By telephone.
   c. At the hospital.
   d. In the examination room.

2. In triaging a patient phone call, the person receiving the call may:
   a. Schedule an appointment.
   b. Take a message.
   c. Refer to the billing department.
   d. All of the above.

3. HIPAA Privacy Standards must be applied when determining the information that can be shared in a phone call with the relative of a patient.
   a. True
   b. False

4. A patient calling to schedule an appointment with symptoms of sudden vision loss can be scheduled at some time within a week. There is no urgency to scheduling the visit.
   a. True
   b. False

5. Patient’s charts are prepared at the time the patient arrives for his/her appointment.
   a. True
   b. False

6. Patient registration processes are normally completed:
   a. For all patients with past due accounts.
   b. Upon checkout and after their appointment is complete.
   c. Upon check-in.
   d. At the time the appointment is made.

7. If a patient arrives for an appointment without a necessary insurance authorization,
   a. The patient is seen regardless, since authorizations really don’t matter.
   b. An attempt is made to obtain the authorization, so that the patient can be seen.
   c. The patient is given a free exam.
   d. The patient is allowed to file charts to pay for the exam.

8. Encounter forms are most commonly used to:
   a. Record the patient’s history and physical condition.
   b. Record the patient’s complaints.
   c. Record the diagnosis and procedural codes.
   d. Record the patient’s time of arrival.
9. Registration information should be:
   a. Routinely reviewed for each patient upon arrival.
   b. Requested of each patient upon arrival.
   c. Discarded upon entry into the information management system.
   d. Requested if the receptionist believes it necessary.

10. At the conclusion of each encounter, the patient:
   a. Should be efficiently escorted to the door.
   b. Should stop at the check-out desk to determine payment status.
   c. Should be photographed for future practice advertisements.
   d. Should sign a waiver of liability for all services performed.

11. Payment receipts should be used:
   a. Only if requested by the patient.
   b. To prepare bank deposits.
   c. Only for cash transactions.
   d. To record all payments received from patients.

12. Over the past several years, billing processes have become:
   a. More dependent on accurate typing.
   b. More reliant on automated processes.
   c. Totally free of any hardcopy needs.
   d. Less dependent on accurate patient information.

13. The balance due on services rendered by the practice is known as Accounts Receivable (A/R).
   a. True
   b. False

14. Unless unusual circumstances dictate otherwise, patients with outstanding accounts should receive a statement:
   a. Within three days of service.
   b. Upon check-out.
   c. Upon payment.
   d. Monthly

15. The acronym “EOB” represents:
   a. Explanation of benefits.
   b. Exceptional online banking.
   c. Extended outpatient benefits.
   d. Established ordinary banking.