

Revenue Cycle Management



Financial Clearance and Pre-Registration ~ Steps for Success

Presented by:
Kimberly Moore
Director, Health Care Revenue Cycle Consulting
701.239.8673
kmoore@eidebailly.com



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Today's Outline

- ❑ Financial Clearance Steps
- ❑ Financial Conversations: Pre – Encounter, Encounter and Post Encounter
- ❑ Reduce Accounts Receivable days through effective self – pay processes

Sample Functional Process

Functional Process Units and Core Responsibilities

7 days Prior to Point of Service

Patient Access

Practice Management -
Pre Processing Team




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Hospital -Pre Processing
Team



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Financial Advocacy



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- Provider Liaison/Education
1. Pre - Cert
 2. Pre Auth
 3. Benefits
 4. Patient \$ Estimates
 5. Demographic Variance Mgmt
 6. Charity Screening

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Financial Resource
Coordinator



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1. FAP Screen
2. Special Account FU
3. FAP AR follow up
4. Financial Counseling Coverage

Outbound
Financial
Counseling



1. Outbound Calls for Payment in Full/ Approved Agreements

In house Financial
Counseling



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1. In house census Financial Clearance
2. Inbound Patient /customer visits

Visibility

- Improve visibility in upfront performance
 - Determine the value of Show support for point-of-service (POS) cash collections
 - Monitor back-end activity for denials and write-offs
- Create Percentage of Net revenue targets and track them against POS cash collections
 - By Registrar/Financial Counselor
 - By department
 - By Site
- Determine actual versus expected POS collection
 - Base this on the patients plan (Co-pay, Deductibles)



Pre Registration

Processes to optimize Scheduling / Pre-Registration:

- Integration between IT systems for scheduling and pre-registration functions
- All tests are entered into the on line scheduling system
- Physician order is available to the scheduler at time of scheduling
- Hospital policy for documentation required at registration is explained to each patient
- Reminder calls are placed to all patients and include discussion regarding patient balances and point of service collections policies, confirmation of third party coverage, and restates proper clinical preparation for the service.
- Uninsured patients are instructed to meet with financial counselors to complete applications for financial assistance, and income documentation requirements are explained and requested when patient presents for the service.



Pre-Registration & Scheduling KPI's

Key Performance Indicators for Scheduling

Best Practice Standards

Pre-registration rate for scheduled patients	>98%
Percent tests scheduled in system	100%
Medical necessity checking at time of scheduling	100%
Legible order with all required elements at time of scheduling	>95%
Reminder calls for scheduled services	100%
Number of calls per test scheduled ¹	individual
Average speed of answer	<30 sec.
Percent inbound call abandonment rate	<2 %
Percent of patients rescheduled, cancelled, no show ²	individual
Percent of patients postponed for lack of pre-certification ³	individual
Next available appointment for diagnostic tests	<24 hours
Call abandonment rate	<2%



Pre-Registration and Scheduling Indicators

Performance Indicator Notes

1. The number of calls per test scheduled is dependent upon the hospital's operational practices. Monitoring the number of calls per test scheduled measures the efficiency of the scheduling and pre-registration departments.
2. Monitoring the percent of patients rescheduled, cancelled, or no shows can provide insight to the effectiveness and communication skills between the patient and the schedulers, and with the physician office.
3. Reschedules due to lack of pre-certification should be tracked in order to identify opportunity for continuous improvement. In addition, tracking postponements by physician office provides valuable information to improve communications and scheduling for each physician.

Processes to optimize Patient Access:

- On-line documentation systems to facilitate the management of the copies of patient insurance cards, driver's license, financial assistance applications, income documentation requirements for those applications, and other written communications
- Integration of the financial counseling function with the registration process
- Integration between the registration system and the patient financial services system
- Discussion regarding patient payment obligations and options for payment is conducted with every patient
- Technology for the registration process including logic to identify common registration errors, and facilitates immediate correction by the registrar
- Assurance that verification is performed with each registration
- "Red flag" systems that identify potential identity theft situations for further investigation with ability to track events for the required reporting under the "Red Flags Rule"
- IT systems and/or reports that identify multiple medical records for the same patients, and helps ensure those duplications are correctly daily
- IT systems that identify claims on hold for registration errors, and help ensure the registrars are required to correct those errors. This process ensures that the team learns from their mistakes, and reduces the number of those mistakes in the future
- Kiosks integrated with the scheduling system and financial systems, able to request patient balances, and obtain electronic patient signatures.
- Improvement of accuracy in estimating patient out of pocket, pricing transparency



Patient Access

Key Performance Indicators for Patient Access

Best Practice Standards

Percentage of claims on hold for registration errors ¹	<1/16 Day of Revenue
Number of statements in returned mail weekly ²	<5%
Percentage of patients waiting greater than 10 minutes for a registrar	<10.0%
Average face to face registration duration (minutes)	10.0
Average Registration Throughput	35 IP, 40 OP
ABN's/MSPQ's obtained when required	100%
Data entry quality compared to established department standards	98%
Master Patient Index (MPI) duplication rate as percent of total registrations	<1.0%

Patient Access Indicators

Performance Indicator Notes:

1. Each facility should monitor the percentage or number of claims on hold for registration errors on a daily basis. By collecting this information, and providing feedback, the organization will continuously improve upstream quality.
2. Each facility should record the number of pieces of returned mail for their population. Returned mail costs the organization in staff time to correct, and in delayed and potentially lost revenue.

Patient Balances

- Collect/Discuss past unpaid accounts
- Use a holistic approach for the entire family of accounts
- Require approval for high dollar write offs and/or special arrangements
- Track staff compliance versus internal policies.

Scheduling

Take inventory of:

1. The number of scheduling routes a patient or provider can take to secure a visit.
2. Any deficiencies in data received during the scheduling process.
3. Scheduling Policies and Procedures.

Scheduling with the patient

If it is the patient calling:

1. Ask if there is an insurance that they would like you to bill.
 - a) If yes, obtain that information while you have the patient on the phone. Either directly or by doing a soft transfer to another department.
 - b) If they do not have the card handy be very specific on next steps and on the facilities expectation from the patient.

Scheduling with a provider

Often times the referring provider will call to schedule appointments for the patient.

1. Ask the provider representative to fax a copy of the insurance card and demographic information.
2. Gather basic demographic information at a minimum.
 - a) Patients name, Date of Birth, Guarantor name if a minor, a day time and alternate phone number and if known the insurance payer information.



Keep them informed

Verbal explanation along with written explanation

- Create a brochure explaining the financial process
- Give them a link to your web site for further details -
Make your website a one-stop destination for facility information, health information, forms and secure messaging with your facility
- Give a direct phone number in case they have further questions
- Repeat the same scripting at EVERY visit. Keep it consistent.



Financial Clearance – Pre Encounter

Financial Clearance should begin as soon after the patient is scheduled as possible and at least 48 hours prior to an appointment.

- Benefit Verification – based upon the service to be offered
 - To include coverage percentages and out of pocket obligations (Co-Pay, Co-Insurance, Deductibles and Non-covered services.)
- Prior – Authorization requirements
- Special billing requirements
- Financial Conversations with the patient



Financial Conversation

All Settings (ED, OP, IP, Clinics)

- List all providers that may be a part of this episode of care
- Inform patients that the actual cost may vary from the estimate
- Ask the patient if they are interested in learning more about payment options.
- Ask the patient if they are interested in learning more about Financial Assistance options.
- Attempt to resolve prior balances (provider balances, agency balances or other organizations)
 - Have dates and amounts – if the patient requests supply a list of services provided
- Provide the patient with written information regarding financial assistance, summary of obligations, include a phone number for questions.



Financial Conversations – Pre Encounter

Based upon your collection policies:

1. Explain coverage information
2. Discuss payment options
3. Assist with Payment Arrangements, Loan Programs, possible other coverage options, and/or Financial Assistance.
4. Discuss expectations prior to the appointment



Financial Conversations – Concurrent

There will be times when the patient presents with out a pre-scheduled appointment.

1. Gather the same information that you would if the patient was pre-scheduled.
2. Follow the same verification process.
 - a) If the service requires an authorization that may not be available prior to the service - determine the urgency of the service before moving to the next step.
3. Have a conversation with the patient regarding their financial obligation.



Financial Conversations – Emergency Department

In the Emergency Department (comply with EMTALA)

- Emergent patients – at discharge
- Non-Emergent – following the medical clearance
 - Registration will gather basic information after medical clearance (Demographic, Insurance coverage, need for assistance)
- Inform patient that their inability to pay will not interfere with treatment of an emergent condition.
- Uninsured informed that the goal is to identify payment sources or financial assistance options
- After Medical clearance screening verify coverage
- Financial Counseling



Financial Conversations – Post Encounter

- Follow up with any patient that did not receive a visit from a financial counselor.
 - Timing is very important. Be sure to follow up with in 1-3 business days after discharge.
 - Ensure that the patient understands the financial paperwork given at admissions and/or discharge
- Follow up post encounter for paperwork that may have been requested.
- Follow up on promises to pay.



The Affordable Care Act

- Be strategic and develop ways to assist your patients on understanding how to enroll
 - This will help reduce unnecessary bad debt and charity expenses
- Consider reviewing your workflows to ensure that your front line has the proper education
 - Investigate having your registration team become Certified application counselors
 - Consider having extra computers at patient access points to navigate your policies, exchange questions, Centers for Medicare & Medicaid services
- Create Brochures and display Posters
- Do Outreach services at Community Centers etc.



Self-Pay Management

Uninsured patients:

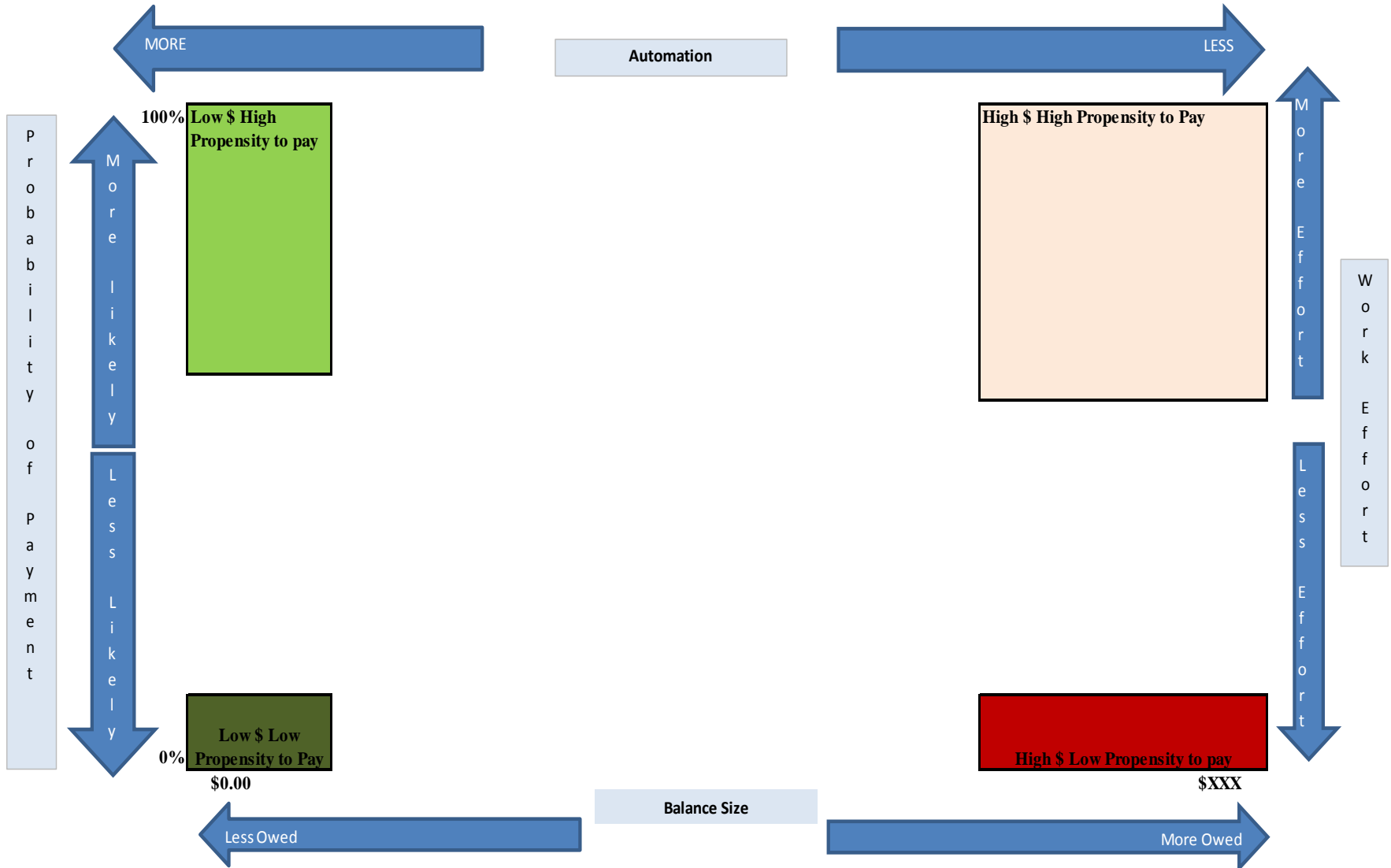
- Begin conversations with the patient regarding payment options at scheduling.
- Let them speak with a focused Self Pay Financial Counselor that can work with them through out the entire billing process
- Be sure that you have a very robust workflow, either electronically or paper flow to ensure that EACH of your uninsured patients speak with a Financial Counselor prior to their visit.
- A recent study showed that as much as 31% of bad debts written off were for patients who would have qualified for Financial Assistance.
 - To search for other payment sources
 - To set up financial arrangements
 - To verify financial assistance
 - To ensure the you are following the 501 (r) requirements

Self Pay Risk Segmentation

Self Pay Risk Based Segmentation

- Technology is the key to success for this method
 - Score and Stratification of Self pay receivables by propensity to pay or risk.
 - This method would be applied at multiple stages of the revenue cycle process: Pre-Registration, Point of care, discharge and at the back end collection process.
- As a result of the information gathered the Revenue Cycle team can make data driven decisions:
 - Out source vs. In-source
 - Human resources vs. Automation
 - Patient interaction approach
- As a result Finance would also have a truer valuation of the self pay inventory from a liquidity perspective.

Self Pay Propensity





Securing Payments to reduce AR Days

Change your up front conversations

- Ask for: Insurance Cards, Driver's license and now **Credit Card.**

Use a credit card on file:

- At check out to pay: Co-pays, Co-insurance, Deductible, Non-covered services
- After the EOB is received and any balances (+/-) can be taken care of with out a statement.
- Work with your Credit Card Gateway to ensure PCI Compliant Credit Card Processing



Scripting

#1 Example: Mr. Jones – We have verified your insurance and they require us to collect a \$50 copay for each visit. How would you like to take care of this today, cash or credit? (Then be silent)

#2 Example: Mr. Jones – you are having a procedure today that requires a deposit of \$_____ I see that Amy our financial counselor spoke with you on Tuesday and you indicated that you would be paying by check, is that still the method of payment that you would like to use? (then be silent)

Remember: It is a contract between the patient and the insurance.



Disclaimer

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