



Patient Access

“The Big Opportunity”



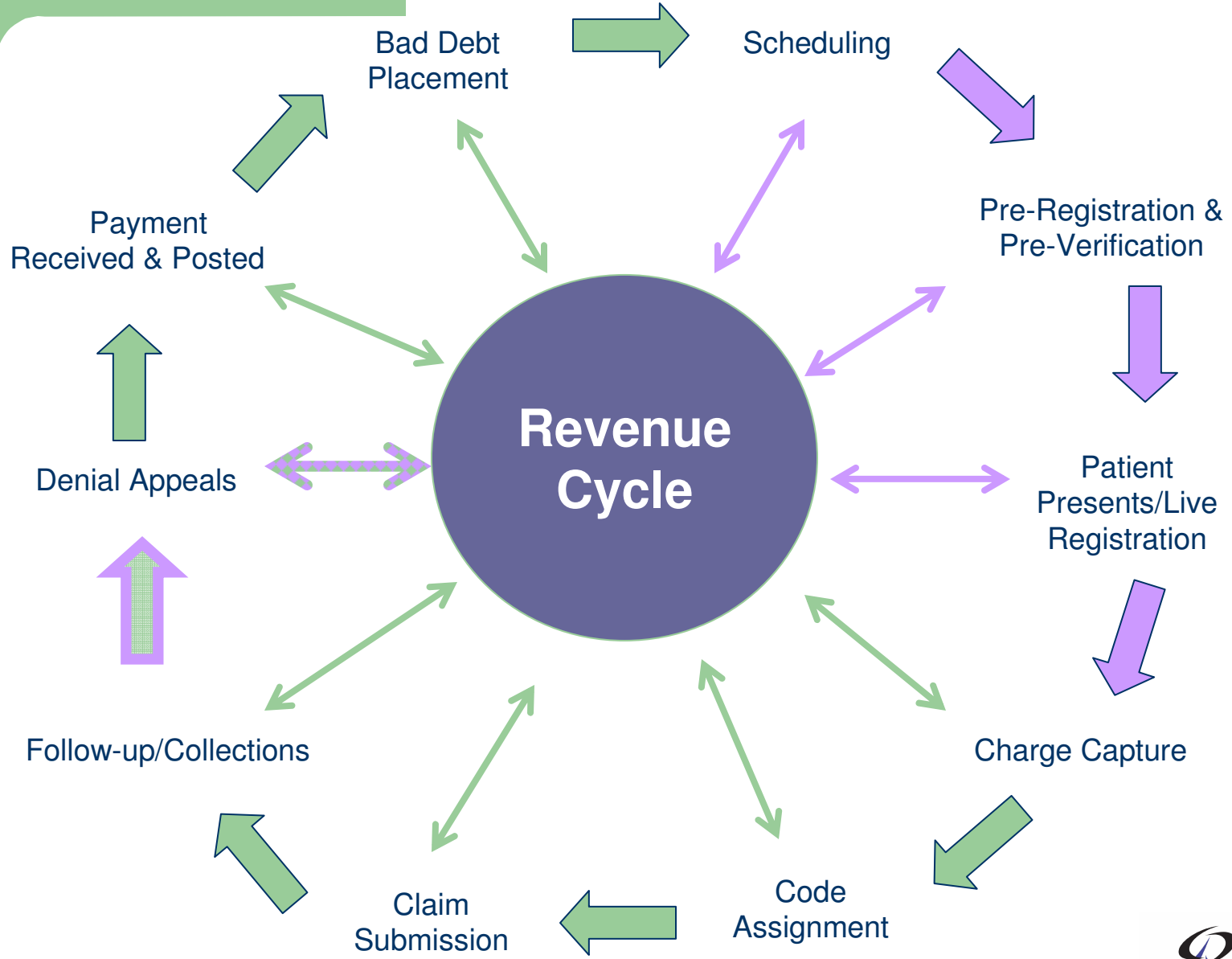
Evolution of the Revenue Cycle

Over the last 10 – 15 years the industry has Increased

- Awareness
- Understanding
- Recognition

Leading to.....

- Use of Key Performance Indicators
- Greater industry consensus on national average & best practice measurements
- Achievement of best practice levels
- Revenue Cycle positions established
- Internal Revenue Cycle Teams



IMPROVING REGISTRATION ACCURACY

ACCESS MANAGEMENT JOURNAL

By Paul Shorosh As a newly-installed business office director at a 250-bed hospital with decentralized registration, I was astounded by the number of complaints I got each week from billing, collections, HIM and even IT departments, all pointing to data quality errors made during patient registration. It was, without a doubt, the number one internal complaint of the business office, which included patient financial services (PFS), billing, collections and patient access departments. After years of brow-beating, the complaints had desensitized my access employees, so my first inclination was to protect them. But at the same time, they needed to improve their accuracy rate for billing. I needed a way to monitor and track accuracy, and somehow bridge the divide between front and back. Soon I began to envision a way for patient access employees to self-correct and learn from their mistakes. I started by analyzing the complaints and ranking them by frequency and impact. I studied remit denials, billing system reports and interviewed billing staff to identify the top five registration errors, then the top 10, until I understood what was going on. The errors fell into three categories: financial, operational and compliance. Financial errors would stop or deny the claim, such as missing guarantor or subscriber information, invalid policy or group numbers, or missing authorizations. Accident claims with missing occurrence codes were problematic, as were incomplete workers' compensation claims, **Studies**

estimated that as much as 80 percent of billing office staff time was dedicated to rework³.

And what really caught my attention, were estimates that 50 percent to 90 percent of claim denials could be prevented by securing accurate patient information at the front door.^{4,5} 7 most of my counterparts, I understood fully the "garbage in, garbage out" theory. But every article I read and every workshop I attended recommended some form of manual quality review as the only solution. I

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4 Pesce, J., "Stanching H
Hemorrhage with Informa
Health Management Tec
5 Atchison, K. *Healthcare*
May/2003

Patient Access: A New Face For the Revenue Cycle

Michael S. Friedberg

Patients' first impressions of hospitals are likely to improve dramatically as a result of recent breakthroughs in managing the revenue cycle's patient access processes.

At a Glance

Patient access management requires skilled staff to fill the new role of patient representative.

Unlike registrars in the past, patient representatives must perform a diverse and complex range of tasks, including reviewing referrals, obtaining authorizations, verifying eligibility, and requesting payment at time of service.

Providing patient access staff with adequate training and ensuring they undergo sufficient quality assurance monitoring are critical steps to effective patient access management. It is not far-fetched to call scheduling and registration processes the "face" of a hospital's revenue cycle operations. A patient's first encounter with a hospital's revenue cycle typically occurs with these processes, and it is here where the patient forms his or her first impressions of the hospital. Yet for many years, the evolution of these patient access functions lagged behind that of other areas of the revenue cycle. Today, these circumstances have changed, as new developments in patient access are raising this area to new levels—and giving hospitals the opportunity to present a new face to patients.

U.S. hospitals have long used sophisticated methods and technology to manage other key revenue cycle processes. Over the past 20 years, keeping step with the increasingly complex requirements for managing coding and billing processes, hospitals have seen their business offices evolve into patient financial services, and medical records transform into health information management. Today, patient admitting and registration processes are undergoing a similar transformation as patient access management has become the latest area of focus in the development of the hospital revenue cycle—with the promise of

Patient Access Management Benefits

Patient access functions have long been the revenue cycle's Achilles heel—with poor data collection providing a classic example of "garbage in" producing "garbage out."

The causes of poor data collection during the registration process are well documented:

Lack of initial formal training

Absence of routine, periodic retraining

Lack of feedback on error rates, resulting in a lack of accountability for errors

Pressure to register patients rapidly, often at the expense of data quality

Lack of tools necessary to accomplish the tasks required

Complex systems that provide too many choices

Patient access management aims to eliminate these deficiencies. The improvements from creating such a department can not only have a direct impact on cash flow and operating cost, wit

From a Ripple to a Wave: Why Eligibility Matters

Pamela M. Waymack & Gwendolyn Lohse

Incomplete eligibility verification can create problematic ripples throughout the revenue cycle. But some healthcare organizations have found a way to keep the ripples from turning into a tsunami.

It is a simple fact of the healthcare revenue cycle; Insurance eligibility drives payment. And as a first step in that cycle – eligibility verification – is the most critical. Unfortunately, eligibility verification is one of the most neglected elements in the revenue cycle.

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Patient Access lags behind due to....

- Inadequate training
- Low pay levels
- High turnover

Patient Access lags behind due to....

- Insufficient Audit & Monitoring processes
- Lack of System integration & optimal use
- Minimal number best practice measurements
- Current best practice goals are too low

Current Patient Access goals

Patient Access Quality

<u>Relevant Metrics*</u>	<u>Best Practice Targets*</u>
Physician authorization compliance	95% compliance
Inpatient admissions error ratio	< 3% error
Outpatient registration error ratio	< 3% error
Point-of-Service Collections	Collect 50% of estimated patient portion at the POS
% of pre-registered inpatient accounts	40%
% of pre-registered outpatient accounts	20%

*Source: HFMA 08 BBBH August.indd

Related Opportunities...

- Increase number of patients with insurance verified prior to visit
- Increase number of patients registered prior to visit
- Increase registration accuracy
- Optimize cash collections
- Improve patient throughput
- Create a better patient experience



Opportunities Realized....

Excuses, excuses....

- Not enough staff
- Not enough time to check insurance
- Not sure of what amount to collect
- Patients don't have the money to pay
- Do not want to upset the patient
- Systems not interfaced

“Plan for Change”

Patient Access.....A Role Re-defined

Responsibilities	Then	Now
Information Capture	√	√
Insurance Verification		√
Check Medical Necessity & ABN Notification		√
ID & Collection of Co-pay		√
MSP Forms	√	√
Error Tracking/Edit Software		√
Reporting		√
Average Pay Level	\$9.00/Hr.	\$10.00/Hr.

Source: RCS client database

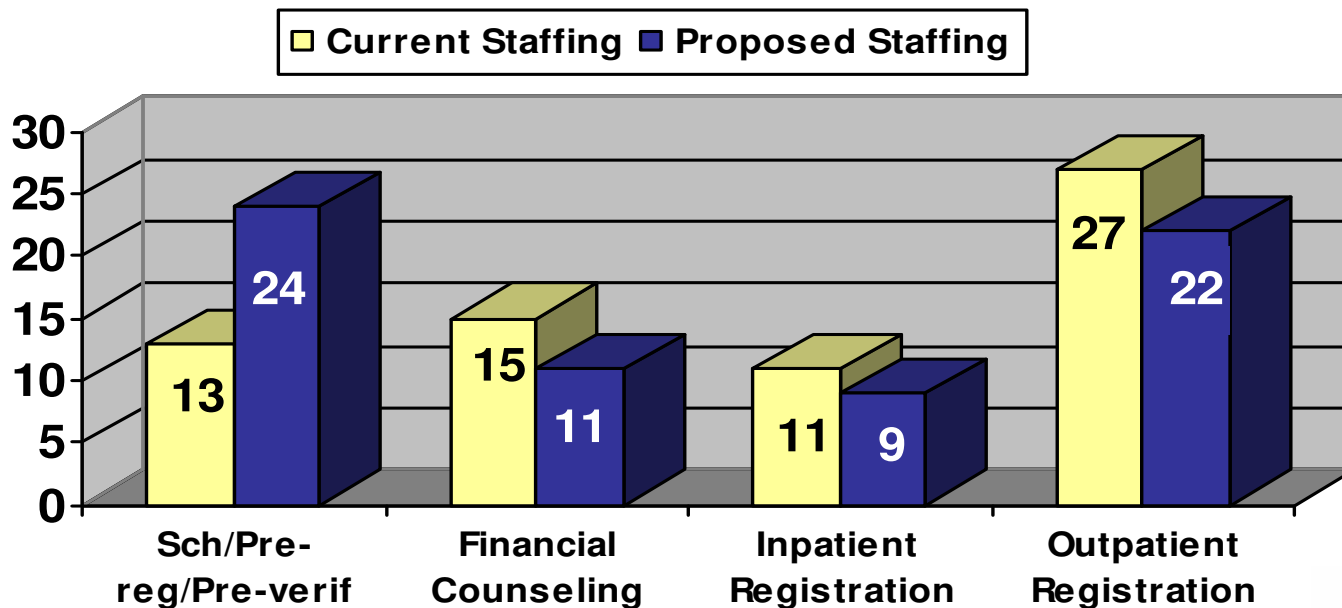
“Plan for Change”

- Training
 - Scope should include:
 - Data capture procedures
 - Insurance verification
 - Registration system/process
 - Collection techniques*
 - Financial counseling
 - Forms and documents
 - Comprehensive testing of trainees **before** assignment
 - Continuing education for existing staff

“Plan for Change”

- Staffing

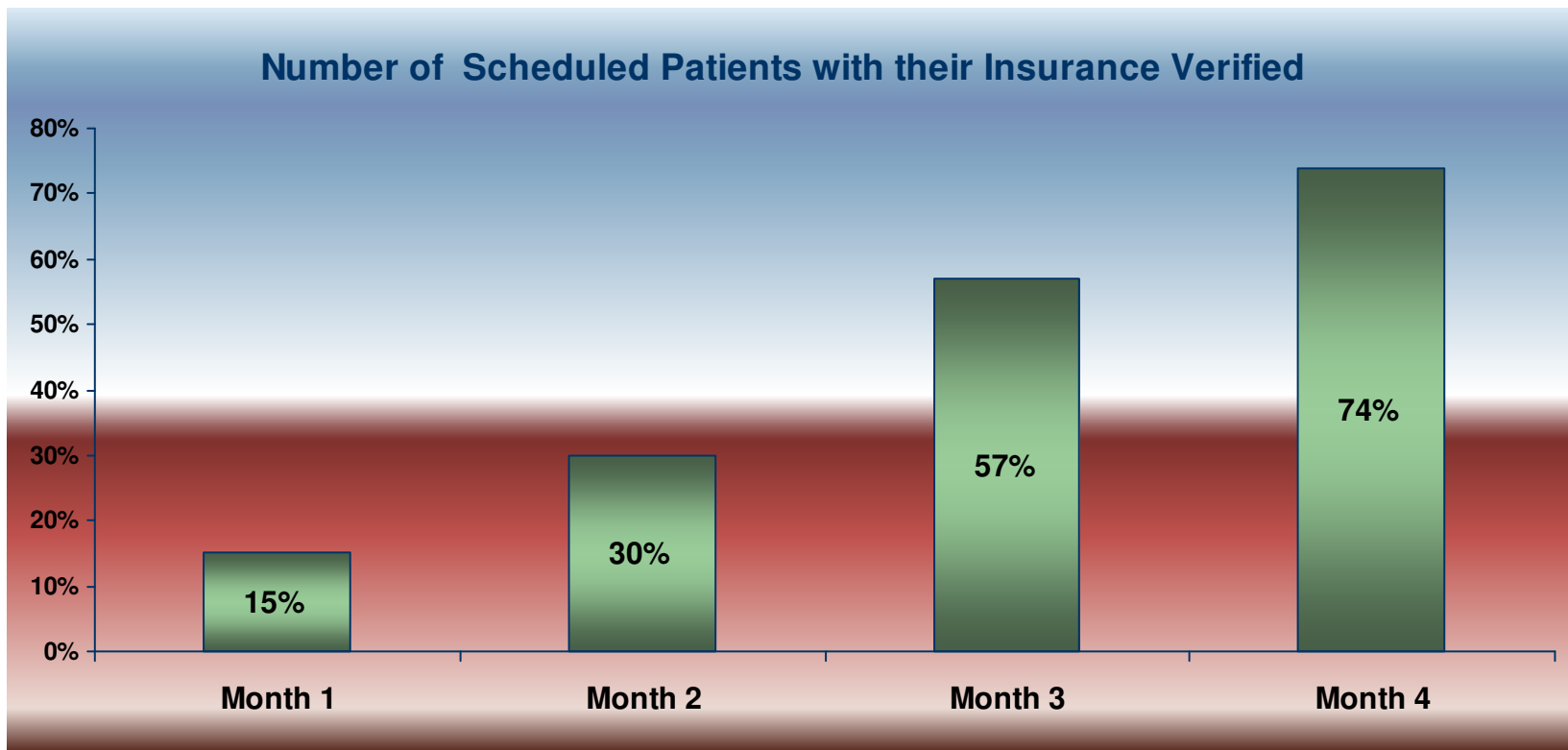
- Migration of Patient Access staff for improved performance



“Plan for Change”

- Insurance Verification
 - Comprehensive insurance verification following scheduling
 - Real-time electronic insurance verification at live registration
 - Identification of patient financial responsibility and levels of coverage

Insurance Verification Improvements



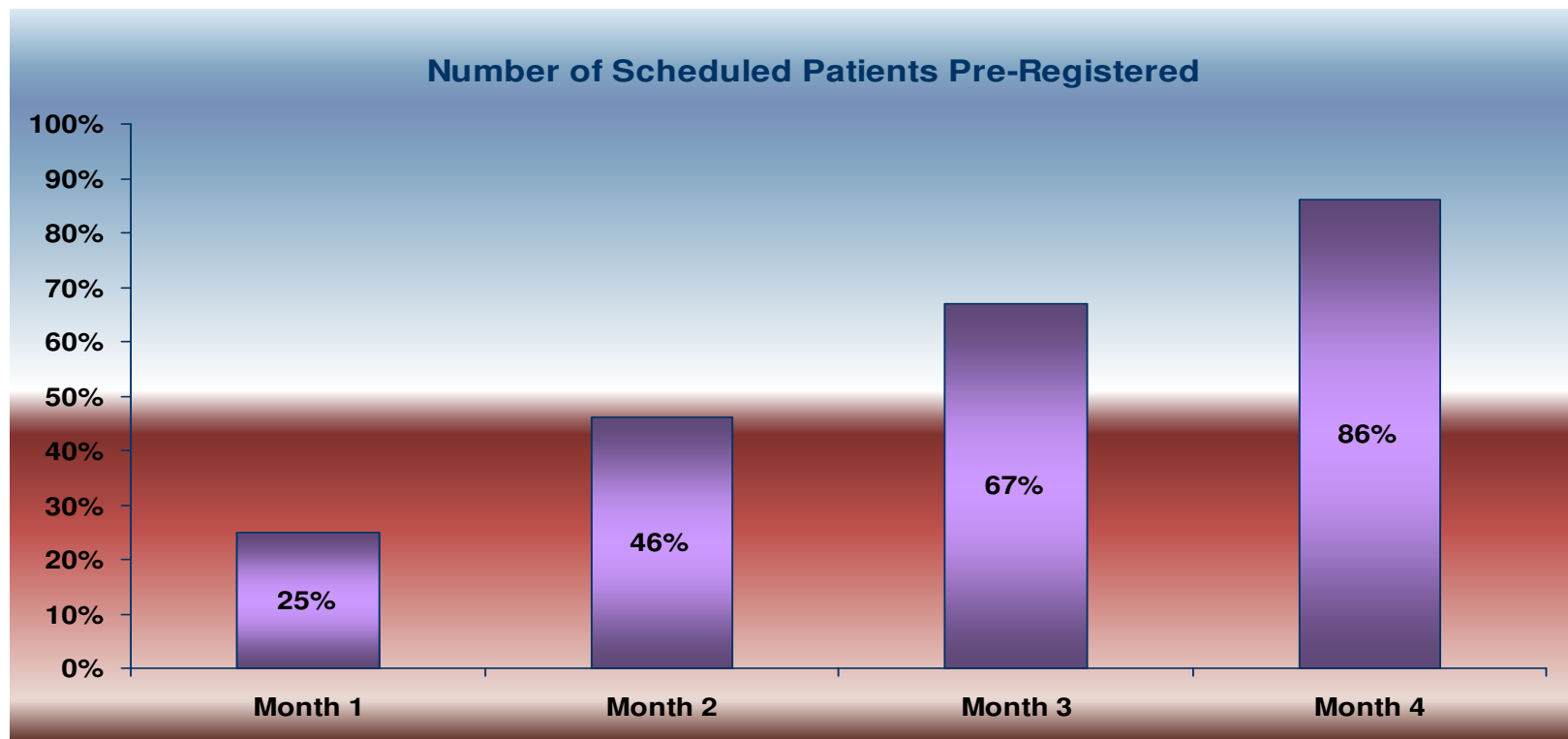
Source: RCS client database



“Plan for Change”

- Pre-registration
 - Pre-register all scheduled patients 3 days in advance
 - Obtain complete and accurate patient information
 - Demographic
 - Insurance
 - Medical
 - Notify patient of co-pay due and collect
 - Investigate other potential coverage sources

Pre-Registration Improvements



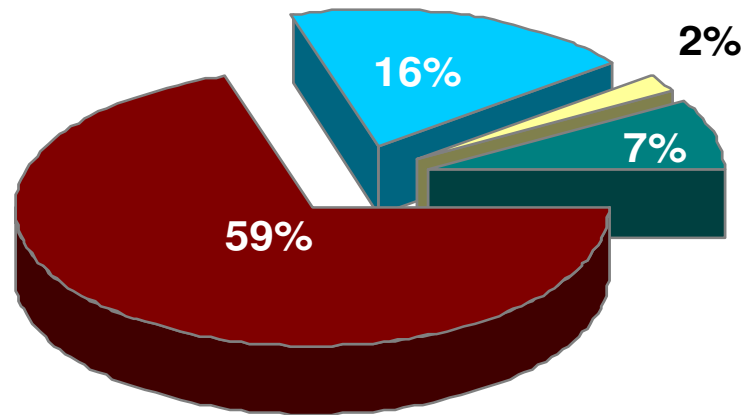
Source: RCS client database

“Plan for Change”

- Registration error measurement & monitoring must include:
 - Demographic
 - Insurance
 - Medical
 - Concurrent monitoring
 - Feedback { Billing Software
Collection/Follow-up Staff
Denials

Typical Registration Errors

Sample Registration Audit



Source: RCS client database

The average hospital performs approximately 120,000 non-urgent registrations annually...

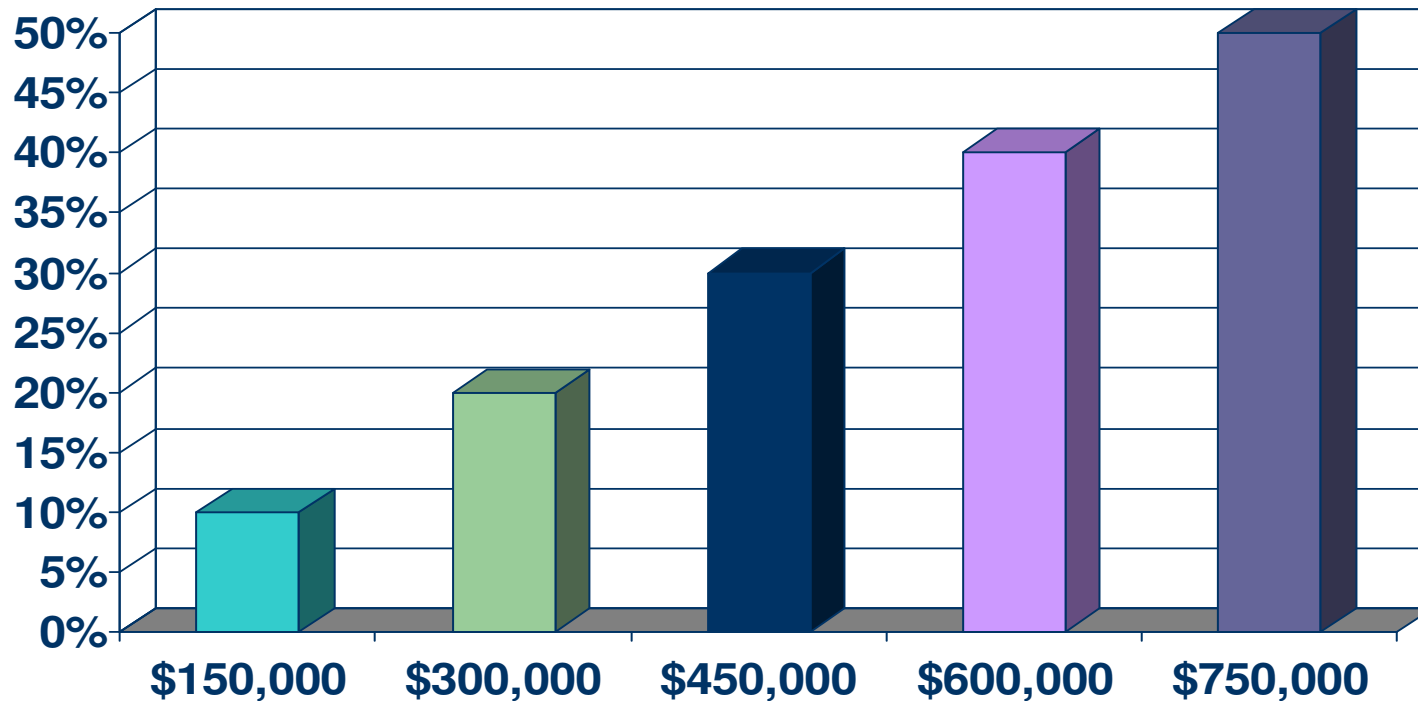
- About 65% of these are scheduled
 - Less than 15% verify insurance prior to services
 - Less than 25% are pre-registered
 - Less than 2% of patient amount are collected

Source: RCS client database

Example:

$\begin{array}{r} 120,000 \\ \times \quad 25\% \\ \hline \end{array}$	Total Registrations Applicable co-payment population
$\begin{array}{r} = \quad 30,000 \\ \times \quad \$50 \\ \hline \end{array}$	Average co-payment due
$= \$1,500,000$	Total Amount Available for Collection

Dollar Impact of... Increasing collections from 10% to 50%

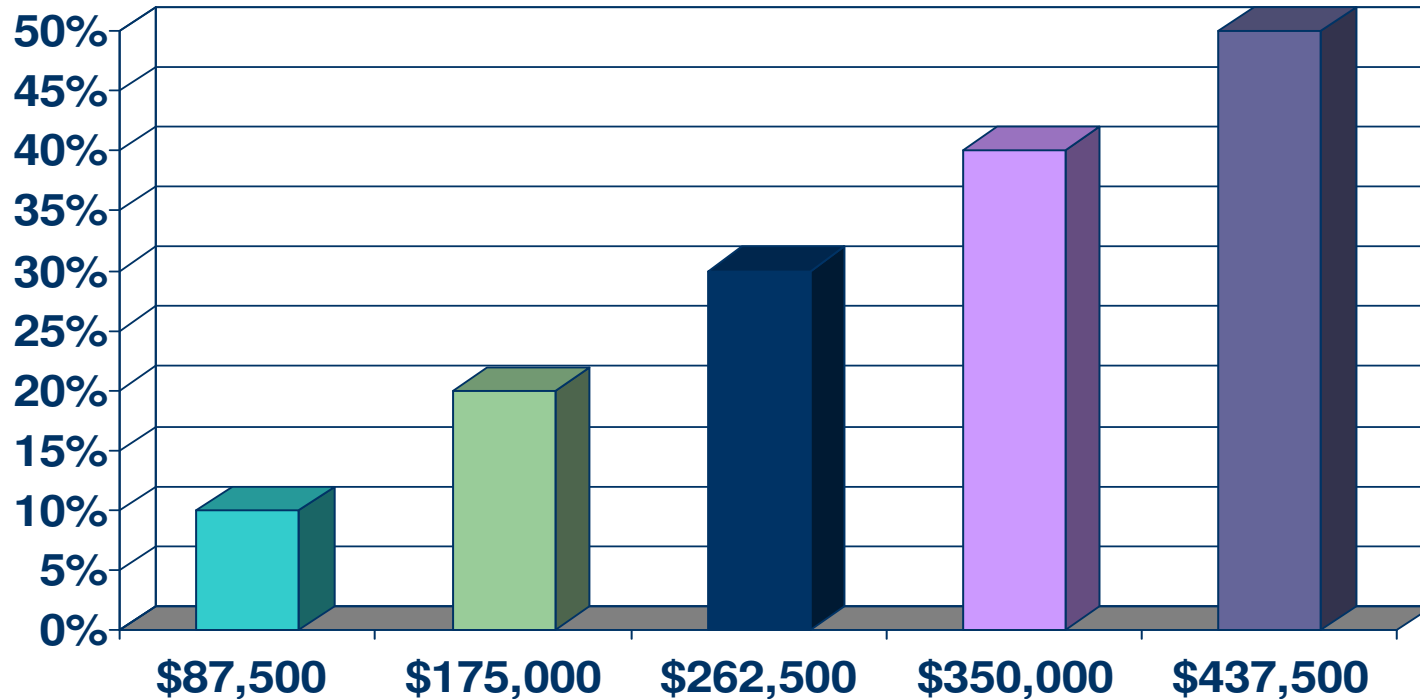


Based on: Estimated 25% with co-payment due.
Average co-payment of \$50

Emergency Department Example:

$\begin{array}{r} 50,000 \\ \times \quad 35\% \\ \hline \end{array}$	ED Registrations (Annually) Applicable co-payment population
$\begin{array}{r} = \quad 17,500 \\ \times \quad \$50 \\ \hline \end{array}$	Average co-payment due
$= \quad \$875,000$	Total Amount Available for Collection

Dollar Impact of... Emergency Department Co-payment collections

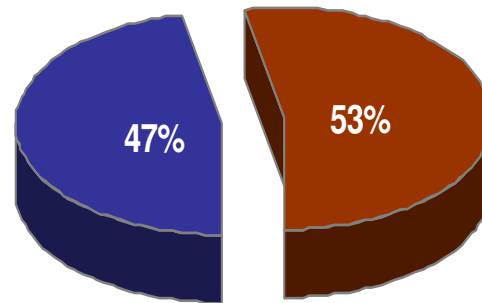


Based on: Estimated 35% with co-payment due.
Average co-payment of \$50

Typical Denial Breakdown

Billing claim denials related to registration errors are preventable through increased training, systems edits and level of integration with real-time support systems

Registration vs. Non-Registration Denials

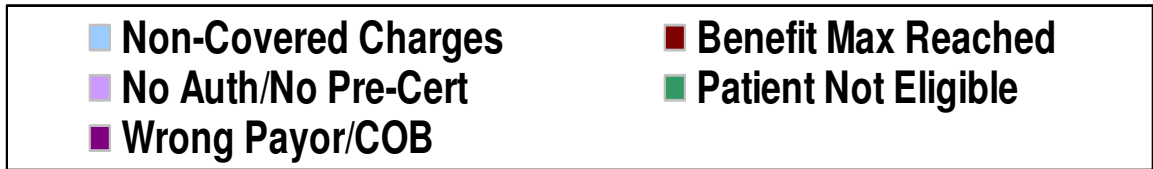
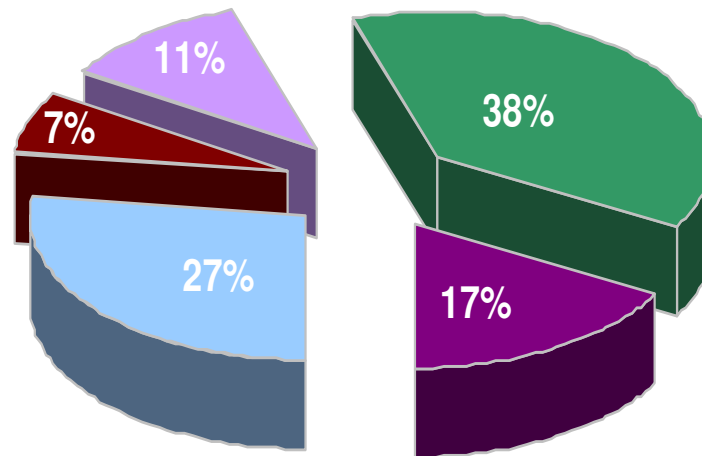


■ Registration Denials ■ Non-Registration Denials

Source: RCS client database

Typical Denial Breakdown

Registration Denial Breakdown



Source: RCS client database

“Plan for Change”

- Systems & Equipment
 - Real-time system edits to guide accurate registrations
 - Verification systems integrated vs. non-integrated
 - Identification and trending of pre-bill / pre-claim edit issues
 - Other necessary equipment to support staff efforts such as telephone, fax & computer

What is Possible?

Function / Effort	Hospital	Target/Goal
% of Non-Urgent Patients Pre-verified	15%	92%
% of Non-Urgent Patients Pre-Registered	25%	92%
Insurance Co-Payments Collected Prior to Services	2%	61%
Insurance Co-Payments Collected at time of Service, specifically in the ED	15%	50%
% of Unbilled AR related to Registration Issues	10%	3%
% of Denied Claims Due to Registration Errors	50%	10%
Average Patient Registration Wait Time	13 Minutes	5 Minutes

Steps to success....

- Staff areas appropriately
- Adequately train all staff
- Schedule as many patients as possible
- Pre-register as many patients as possible
- Pre-verify as many patients as possible
- Audit registrations
- Collect, collect, collect!!

Benefits Realized...

- Increase accuracy of data capture
- Optimize patient through-put
- Increase cash flow
- Reduce claim denials
- Decrease associated bad debt
- Improve patient experience

Western Pennsylvania Chapter
Healthcare Financial Management Association (HFMA)
Education Session - Qualifies for 7.0 C.P.E. Credits

Revenue Cycle
Four Points by Sheraton, Pittsburgh North, Warrendale, Pa
Friday, April 13, 2007

- 7:30am - 8:00am **Registration & Continental Breakfast**
Walk-ins Welcome
- 8:00am - 8:05am **Welcome & Introduction**
Sam Baker, President
Western Pennsylvania Chapter of HFMA
- 8:05am - 9:00am **Keynote Speech: *Healthcare***
Jason Altmire, U.S. House of Representatives
4th District of Pennsylvania
- 9:00am - 9:15am **Break**
- 9:15am - 10:30am **Revenue Cycle: Patient Access - “The Big Opportunity”**
Dan Thiry, Principal, Revenue Cycle Solutions, LLC
- 10:30am - 11:45am **Denial Management – Impact and Causes**
Jim Tarasovitch, CFO, Bradford Regional Medical Center
Bill Schaude, Partner, ACS Healthcare Solutions
- 11:45am - 12:45pm **LUNCH - “Working Lunch with Presentation”**
- Update on CDHPs**
Loren Rothschild, United Healthcare
- 12:45pm - 1:00pm **Break**
- 1:00pm - 2:15pm **Patient Access Workshop**
Dan Thiry, Principal, Revenue Cycle Solutions, LLC
Colleen McMahon, Senior Consultant, Revenue Cycle Solutions, LLC
- 2:15pm - 3:30pm **Denial Management Workshop**
Jim Tarasovitch, CFO, Bradford Regional Medical Center
Bill Schaude, Partner, ACS Healthcare Solutions
- 3:30pm **Adjournment**