STROUDWATER

OPTIMIZING HEALTHCARE FRONT-END OPERATIONS: ENHANCING PATIENT EXPERIENCE & FINANCIAL PERFORMANCE

Ryan Breneman

REVENUE CYCLE MANAGEMENT

Claim Life Cycle

Front End

Transaction Processing

Back End

Pre-Claim

- Contract Negotiations
- Provider Credentialing
- EDI/ERA Enrollment
- Banking Setup
- CDM Creation
- Price Transparency/No Surprises Act

Pre-Visit

- Scheduling/ Pre-Registration
- Insurance Verification
- Prior Authorization
- Appointment Reminders

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- Patient Check-In
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Accounts Receivables Management

- Claim Status
- Denials Management
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- Patient Statements/Patient Notices
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- Collections Process (In/Out)

Analytics

- Clean and Meaningful Data
- Process Measures
- Financial Measures

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- Month-End Closing
- Cost Reporting
- Compliance
- Performance Management
- IT & Quality

SCHEDULING/PRE-REGISTRATION – BEST PRACTICES

- Put the patient at the heart of the revenue cycle process
- Encourage revenue cycle staff to help build a better business for the hospital by acting as an agent for patient satisfaction and ultimately, loyalty and relationship management
- Provide scripts for staff to follow to provide consistent, high-quality customer service
- Create a pre-registration process to improve “day of” registration process and address noncovered services
- Standardize data provided by referring physicians for scheduled services
- Centralize scheduling for services so patients have one place to schedule all services, and to inform patients of required documents and financial obligations

SCHEDULING/PRE-REGISTRATION – BEST PRACTICES (CONT.)

Develop a process to ensure physician order is available at the time of scheduling, or ensure a process is in place to obtain ahead of the service date

Encourage physicians to use Centralized Scheduling services to help minimize patient dissatisfaction

Pre-register the patient by obtaining and entering the following:

- Patient demographic information such as the patient's name, date of birth, address, telephone number, gender, and race
- Reason for the patient's visit or pre-ordered service
- Insurance carrier information such as the subscriber number, group number, subscriber demographic information
- Employer information
- Preferred pharmacy

PATIENT REGISTRATION ACTIVITIES

Improved Patient Flow and Experience – Reduce wait times and enhance patient satisfaction

Insurance and Eligibility Verification – Reduce claim denials and ensure proper reimbursement

Accurate Patient Identification – Prevent medical errors, duplicate records, and misfiled documentation

Prevention of Uncompensated Care – Reduce the risk of bad debt and uncompensated care

Regulatory Compliance – Meet compliance requirements for Medicare, Medicaid, and avoid penalties

Data Accuracy for Reporting and Funding – Registration data may be used for state and federal reporting

Financial Viability – Errors may lead to delayed payments, claim denials, or lost revenue

Coordination of Care – Enables better communication between departments and external healthcare providers

REGISTRATION

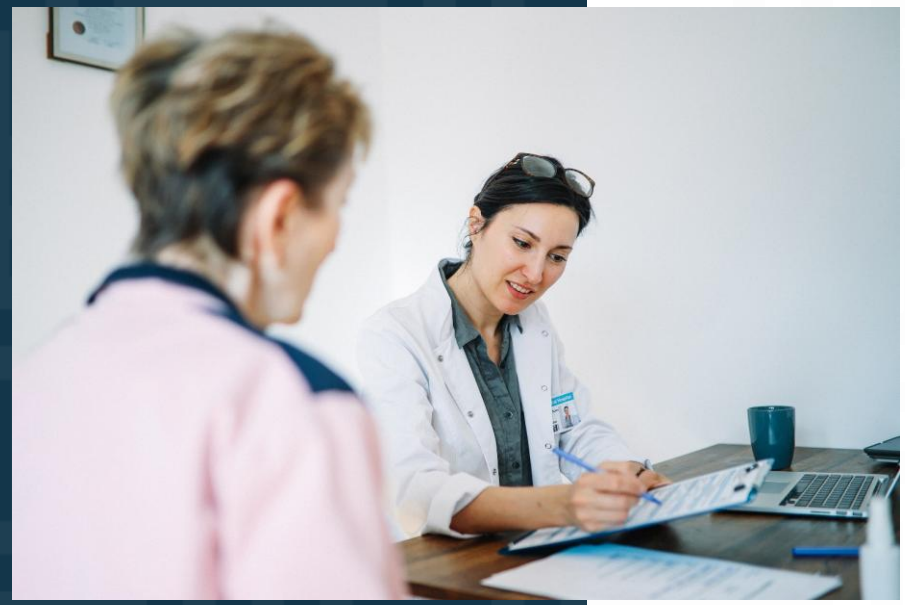
Sets the tone for the patient visit

Can be centralized in one area for all patients or in each ancillary department

Amount of time it will take will vary based on the success of scheduling and pre-registration

Completion of final paperwork (consents and waivers)

REGISTRATION BEST PRACTICES



Perform as much of the process prior to the day of the visit

Maintain similar processes for inpatient, outpatient, emergency department, and clinics with slight variations

Emergency admissions start with a “quick registration” followed by a full registration after the patient has been medically cleared per Emergency Medical Treatment & Labor Act (EMTALA) guidelines

Review insurance information previously obtained

Review if authorization is required for services and confirm authorization number has been received

Communicate potential financial responsibility to the patient

Perform quality audits to provide feedback and coaching to the patient access team

QUESTIONS TO KEEP IN MIND

5 W's and H

Who is going to arrive? (Just patient? Patient and family?)

What will they bring with them? (DL? Insurance cards? Forms?)

When are they going to arrive? How early?

Where will they show up? Which door? Where do they stop?

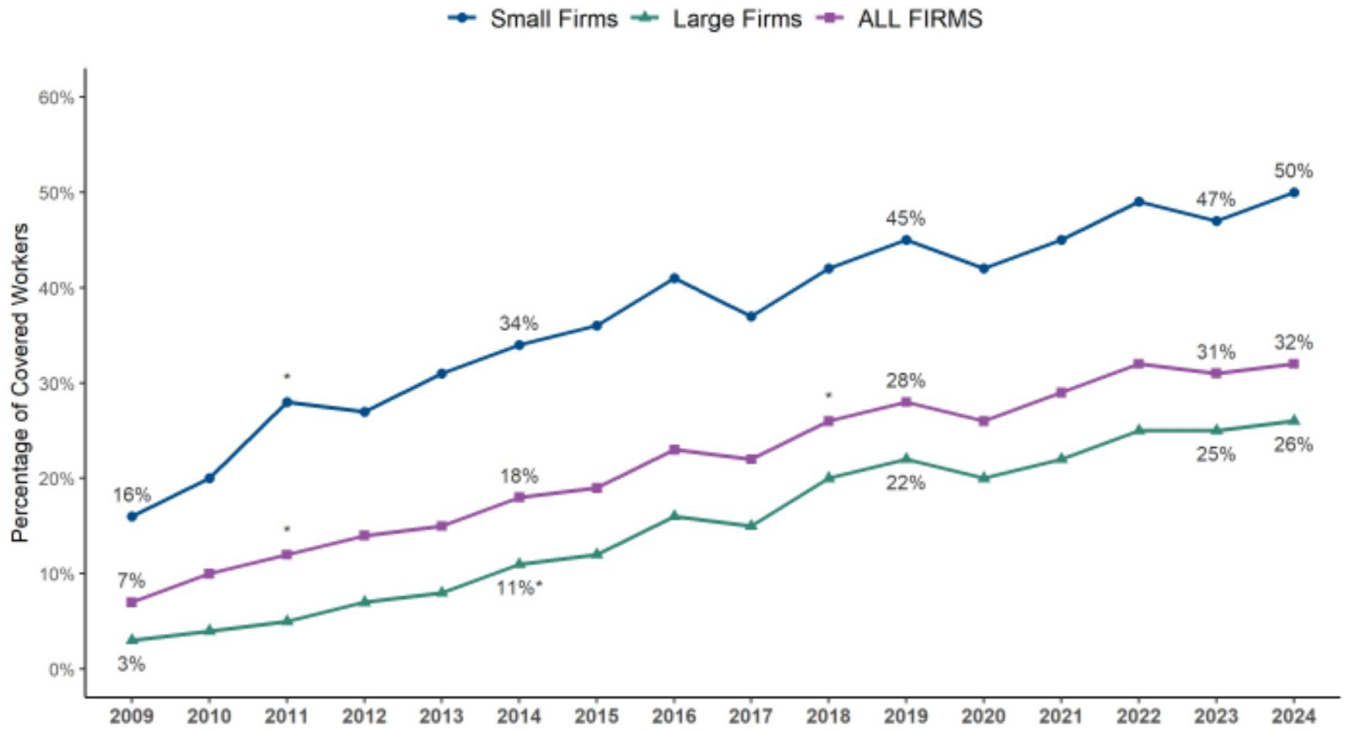
Why are they coming? Do they know all services that might occur?

How will they pay for their services?

KAISER FAMILY FOUNDATION 2024 INSURANCE PREMIUMS

Figure 7.14

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, by Firm Size, 2009-2024



* Estimate is statistically different from estimate for the previous year shown ($p < .05$).

NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network providers.

SOURCE: KFF Employer Health Benefits Survey, 2018-2024; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

INSURANCE VERIFICATION

- Insurance verification is the first step toward receiving payment for services
- Claim denials have been steadily growing year over year
- ACA plans denied an average of 17% of claims in 2021
- Specific plans denied up to 49% of claims

- Payors are using automation and AI to preemptively reject or deny claims that previously may have been paid
- 86% of the denials are potentially avoidable
  - Average cost to work denial $118
  - Proper insurance information streamlines the claim process
- Uses information obtained from the scheduling/registration steps

BEST PRACTICES FOR INSURANCE VERIFICATION

1. Verification should be run on all admissions including reference lab tests
2. Leverage the use of available online verification tools
3. Perform insurance verification on any secondary and tertiary insurance
4. Look for Medicare-aged patients presenting their “Red, White & Blue card” who are covered instead by a Medicare Advantage plan
5. Self-pay patients may qualify for state Medicaid coverage or charity care
6. Predetermine if services will meet medical necessity or need Prior Authorization
7. Identify required co-payments, deductibles, and previous balances
8. Ascertain if “No Surprises Act” provisions are required (i.e., Good Faith Estimates, Notice and Consents)
9. Track insurance verification rate to ensure process is efficient and effective
   - Total number of verified encounters/Total number of registered encounters

PRIOR AUTHORIZATION BEST PRACTICES

- Develop a process that crosswalks insurance plans, CPT codes, and authorization requirements
- Identify resources to perform Prior Authorization tasks, with backups trained to perform activities when the primary resource is out of the office
- Establish specific policies around authorization management and detail scenarios for exception
- Develop processes between the Prior Authorization team and clinical services for Prior Authorizations needed once patient encounter/stay has begun (i.e., transfer to swing bed)
- Communicate outstanding cases needing pre-certifications to administration and appropriate clinical staff
- Implement checks for missing authorization for high-risk areas
- Trend and analyze missing and/or invalid authorization denials to identify potential changes to plan requirements

ENCOUNTER DOCUMENTATION BEST PRACTICES

Your Clinical Documentation Integrity (CDI) team is the heartbeat of the hospital, ensuring accurate, comprehensive encounter documentation, quality care, compliance, and optimal reimbursement

Top leadership should be engaged and provide support to implement and sustain a CDI program

Monitor the following CDI Metrics

- Case mix index (CMI)
- CDI professional's review rate
- Query rate, response rate, and response time
- Quality and reimbursement impact

Develop a (CDI) program that:

- Has a physician advisor that can champion quality documentation practices
- Physician advisor engages other physicians by addressing admission denials, Diagnosis Related Group (DRG) revisions, and other documentation discrepancies that may lead to poor quality care

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WINNING THE DENIALS BATTLE: BEST PRACTICES FOR PREVENTION AND RESOLUTION

Amy Graham

REVENUE CYCLE MANAGEMENT

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CLAIM REJECTION VS. CLAIM DENIAL

Claim Rejection: Not accepted by the payer

- Rejected at the front door
- Incorrect or missing data
- Provider's clearinghouse or claims scrubber finds no insurance subscriber listed or number is invalid
- Timely Filing Window still ticking

Claim Denial: The insurance carrier processes and deems it unpayable

- Fully in payer system, but not paid
- Claim submitted timely, now appeal clock begins ticking

CLAIM STATUS BEST PRACTICES

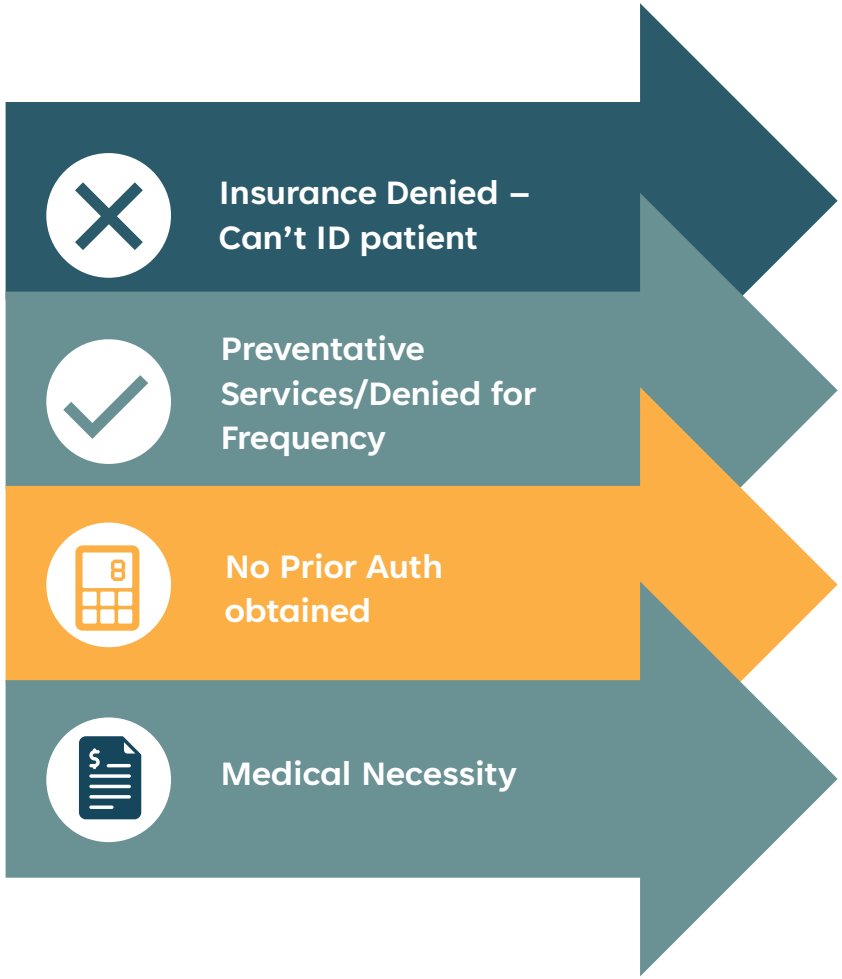
- **Work Payor Payment Dates**
  - Follow up on claims outside the typical payment date range
  - Timely filing limits
- **Look for Trends by Payor**
  - Consistent outstanding balances
  - Specific provider claims
- **Focus on Appealed Claims**
  - Needing clinical support
  - Communications received from payor
- **Monitor Claims by Claim Filing Date**
  - Claims stuck at the Clearinghouse
  - Claims not received at the payor

GOALS OF DENIAL MANAGEMENT

- Root Cause Analysis/Trend Identification
- Payer Relations and Communication
- First Line of Defense/Protect the AR

DENIALS MANAGEMENT

Get to the Root of the Problem



Does the facility have eligibility software?	Is insurance updated every visit?	What documentation is used to ID patient?
Is ordering provider tracking frequency?	Does denial team inform provider of frequency issues?	Has payer policy on frequency changed?
Is test required to be authorized before service?	Does facility have prior auth team and process?	Does scheduling date allow for time to obtain prior auth?
Are payer policies known and housed somewhere for viewing?	Does denial team inform ordering and servicing departments?	Are HIM and coding performing proper review?

HOW TO SPOT TRENDS AND ANOMALIES

Ask questions and continue to dig

Ask “why” three times

Look at the information differently

Are particular payors, aging buckets, or services more problematic than others?

Look at the entire process, not just financial numbers

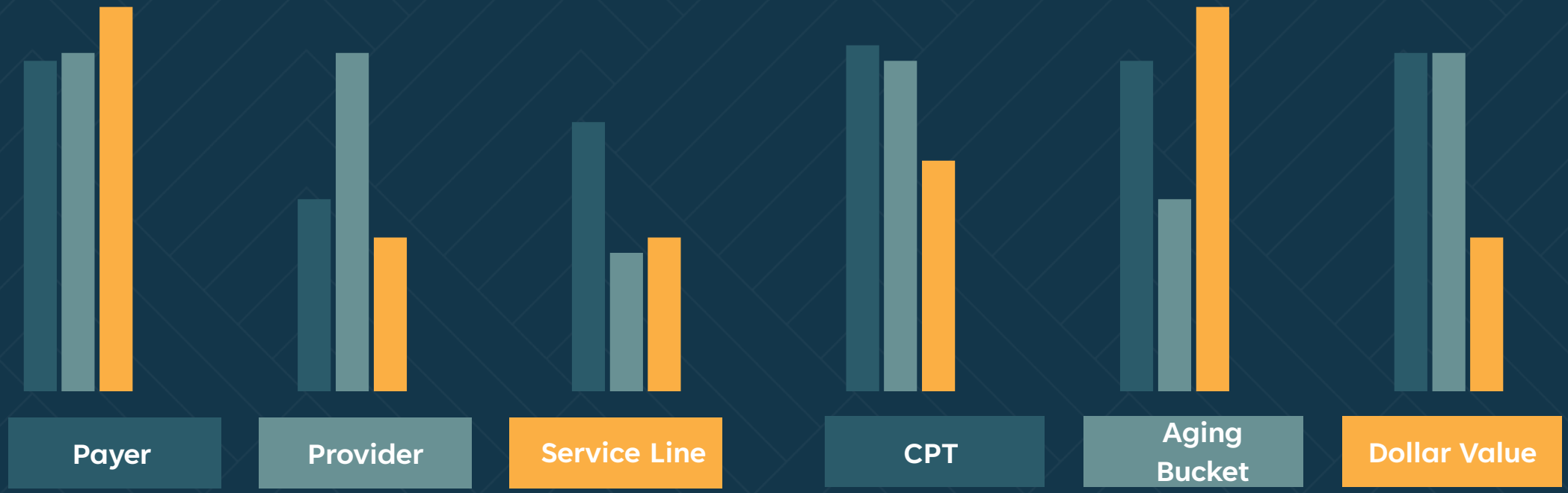
Root cause may be hidden under layers of nuance; consider if any operational changes have occurred

The first answer isn’t always the right answer; dig deeper

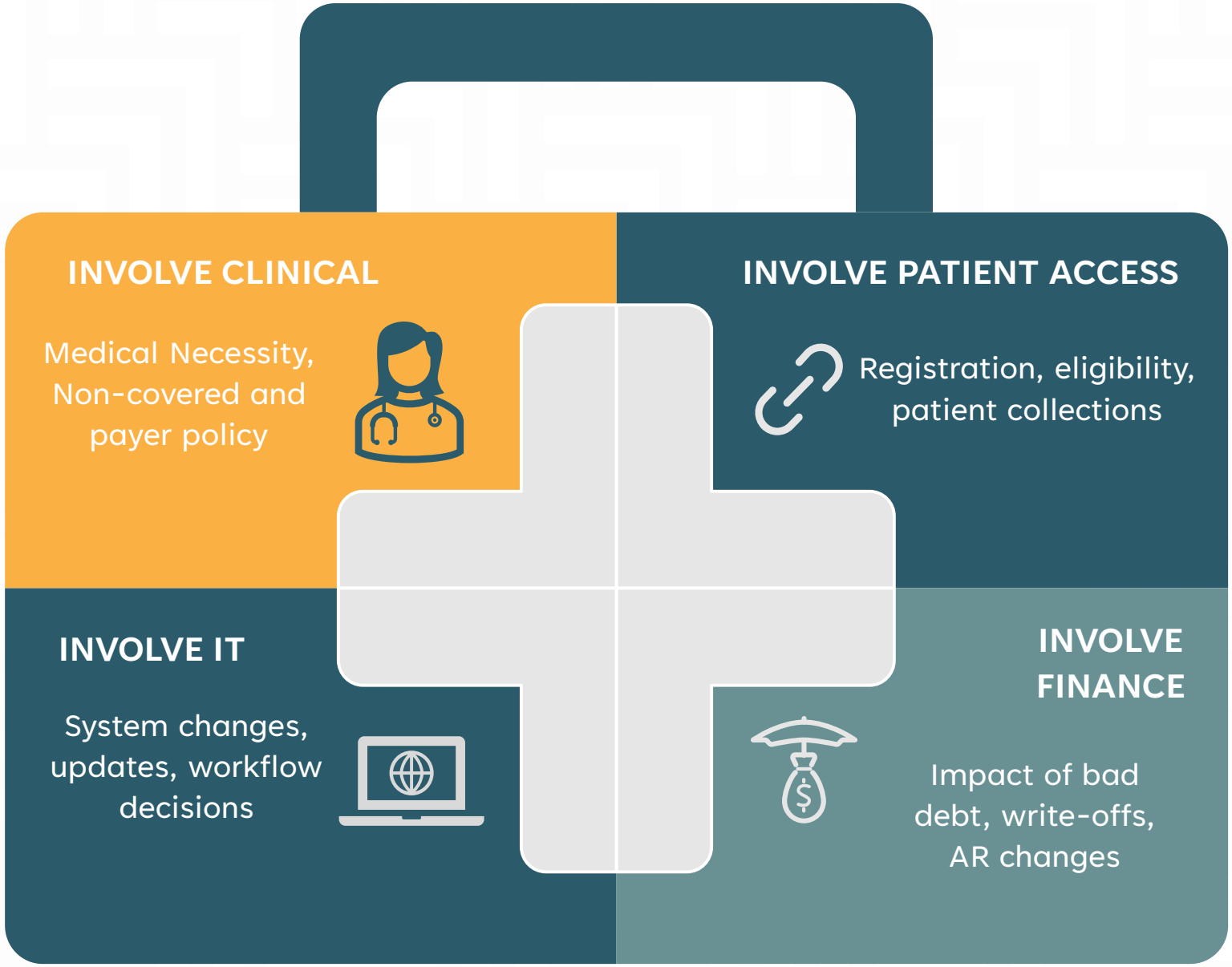
Multiple variables are impacting most metrics, so multiple factors could be contributing

LOOK AT DENIAL/REJECTION DATA IN DIFFERENT WAYS

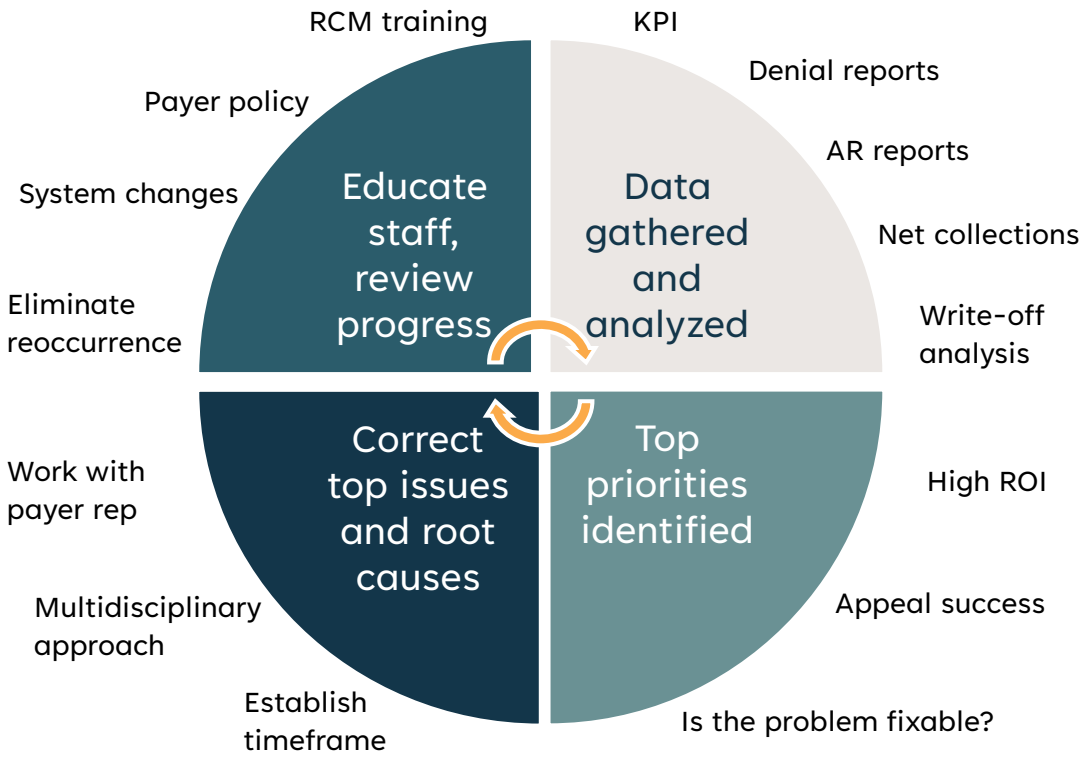
- ✓ Different views provide new data
- ✓ Identify pockets of opportunity
- ✓ Does data pass the smell test?



DEVELOP A MULTIDISCIPLINARY APPROACH



WORKING DENIALS REQUIRES CONTINUOUS IMPROVEMENT



- Track key metrics and establish top priorities
- Set short-term goals for correcting major issues
- Foster a culture of continuous improvement
- Continuously train and educate revenue cycle staff on changes to payer policy or behavior

DENIALS MANAGEMENT/APPEALS & RESOLUTION

Insurance denied - Can't ID patient

- Does the facility have eligibility software?
- Is insurance information updated at every visit?
- Is the patient identified using two pieces of information?
- Free text fields to recognize payor

Preventative services denied for frequency

- Is ordering provider properly tracking frequency?
- Does follow up department report frequency denials by ordering provider?

Denied for lack of preauthorization

- Are providers required to preauthorize before booking tests?
- Do department order intake processes include obtaining preauthorization verification before scheduling?
- Does the facility have referral management or preauthorization teams?
- Are exams booked too closely to DOS to verify and correct authorization?

Medical necessity denial

- Is service denied appropriately?
- Does follow-up maintain an online library of payor-specific policies?
- Does follow-up understand available payor-specific medical policies?
- Are denials reported back to ordering and servicing departments for education?
- Are HIM and coding performing proper review?

Billing process

- Are procedures reviewed by coding before submission?
- Were proper services and diagnosis codes billed?
- Do billers change claims to satisfy clearinghouse edits?

BUILD A RELATIONSHIP WITH YOUR PAYERS

- Review remittances and be informed of payer behaviors before conversations with provider reps
- Establish regular contact with your representatives to clarify changes in payments, denials, or other issues
- If no payer rep is available, can you access payer policies and changes to policies, and understand how your contract states you should be paid?
- Know what payers cause the most headaches, have the greatest ROI, and which contracts may not be as valuable

THE VALUE OF ANALYTICS IN RCM

- Enhanced Revenue Capture - Identify leakage throughout RCM
- Identify bottlenecks and areas where staffing is misaligned with goals
- Provide clarity and bring teams together on common goals
- Assist in messaging to teams and leadership
- Highlight best opportunities for additional collections
- Predict denials and identify root cause
- Increase patient satisfaction and financial transparency
- Show organization-wide trends and areas of success and opportunity

KEY PERFORMANCE INDICATORS FOR REVENUE CYCLE

Account Resolution

- Aged A/R as a % of total billed AR
- Aged A/R as a % of billed A/R by payer
- Aged A/R as a % of total AR
- Remittance denial rate
- Denials as % of net patient service revenue
- Bad debt
- Charity care
- Net days in credit balance

Patient Access

- Percentage of patient schedule occupied
- Pre-registration rate
- Insurance verification rate
- Service authorization rate – inpatient and/or observation
- Service authorization rate – outpatient encounter
- Conversion rate of uninsured patients to third-party funding source
- Point-of-service (POS) cash collections

KEY PERFORMANCE INDICATORS FOR REVENUE CYCLE (CONT.)

Financial Management

- Net days in accounts receivable
- Cash collection as % of net patient service revenue
- Uninsured discount
- Case mix index
- Cost to collect
- Cost to collect by functional area

Pre-Billing

- Days in total discharged not final billed
- Days in total discharged not submitted to payer
- Days in final billed not submitted to payer
- Total charge lag days

Claims

- Clean claim rate
- Late charges as % of total charges

STROUDWATER

COMMITTED TO INCREASING THE IMPACT OF RURAL AND COMMUNITY HEALTHCARE.

Our team of rural and community healthcare experts support the leadership of hospitals, health systems with a rural footprint, and the groups and clinics that form an essential care network across the 97% of the US that is defined as rural.

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Real-world, mission-critical, actionable advisory services as you and your community navigate the dynamic risks of today's healthcare environment.

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We're proud of our 37-year track record with rural hospitals, community hospitals, healthcare systems, and large physician groups.

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- Population Health Strategies
- Physician-Hospital Alignment
- Strategic Facility Planning
- Capital Planning & Access
- Post-Acute Care Strategy

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- Performance Improvement & Restructuring
- Provider Practice Operations Improvement
- Revenue Cycle Solutions
- Post-Acute Care Operations
- Payor Contracting Advisory
- Staffing & Productivity Improvement
- Cost Report Reviews and Analysis