OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

CAH Finance and Operations Webinars

August 3, 2023
How to Build Revenue: Front-End Competencies

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision statement is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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Webinar Logistics

- Audio muted and video off for all attendees.
- Select to populate the ··· to populate the chat feature on the bottom right of your screen. Please use either the chat function or raise your hand on the bottom of your screen to ask your question live.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/resources-and-technical-assistance-cahs.

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Upcoming CAH Operation and Finance Webinars

Aug. 31, 12 p.m. – 1:00 p.m.
The No Surprises Act: Revenue Protections and Transactional Compliance

Sept. 14, 12 p.m. – 1:00 p.m.
Fund Your Mission: Practice Steps to Move from Volume to Value

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Carrie Bova has over 15 years of experience managing revenue cycle operations. Carrie is an expert in optimizing revenue cycle operations and improving cash flow in rural healthcare organizations. She has a proven record of accomplishment of increasing revenue cycle efficiencies, reducing expenses, establishing compliance, and developing growth strategies in a constantly evolving industry. Prior to joining Wintergreen, Carrie worked for multiple rural organizations. Carrie was instrumental in successfully turning one rural hospital that she worked for over ten years into a Critical Access Hospital Top 100 organization.

How to Build Revenue:
Front-End Competencies

August 3, 2023

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Improving Revenue Cycle

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Patient Access staff are often not fully aware of the impact their role has on Revenue Cycle.

Patient Access staff are often instrumental in reducing expenses, patient retention, timely claim payment and customer satisfaction.

Patient Access departments often have high turnover and staffing challenges due to incomplete understanding of their role or inadequate training and continued education.

Best Practices in Patient Access include ensuring the integrity of the registration data collected, insurance eligibility and benefit determination, acquisition of referrals and authorization, medical necessity validation and collection of financial liability and ensuring compliance.

Observations from a Patient Perspective

Do your registration/reception areas appear organized and efficient?
Are your registration processes timely and efficient?
Are staff friendly and knowledgeable?

If your initial impression identifies that any of these initial observations are not favorable, the entire revenue cycle can be impacted and lead to a number of ongoing issues, including dissatisfied patients who may decide not to pursue their care at a facility that appears disorganized.

Any patient registration process is instrumental in making a good first impression of your organization.

Building onboarding processes to ensure that your Patient Access Departments are making an immediate and pleasant impression on patients is critical. Patients prefer short wait times and simple tasks that do not require multiple steps or complicated paperwork.

Impacts

Loss of Patient Retention

Claim rejections or denials due to incorrect or incomplete information gathered at the time or preregistration/registration

Increased and/or additional expense for lack of preservice/point of service collection

Increased or additional expenses related to incorrect coordination of benefits

Compliance issues related to balance billing

Increased days in Accounts Receivable

Patient Retention as a Priority

Patient Retention in an evolving consumerism environment is critical. Patient satisfaction efforts begin with their initial experience, which is always through patient access. The perception of every encounter at your organization is critical to continued patient engagement and service.

- Ensure patient access areas are clean and free from off-putting personal affects.
- Ensure patient access representatives are dressed for success.
- Ensure patient access representatives are friendly and courteous.
- Reduce and automate paperwork for a more patient friendly experience. Use electronic signature pads and employ self-check in kiosk if able.
- Script patient communications to ensure delivery of your organization's message is not misinterpreted and standardized.
- Establish follow up communications or random internal audits to determine patient satisfaction.
- Create registration per encounter stats and expectations.

Telephone Etiquette

Ensure all patient encounters, even those that are non-patient facing, are handled professionally, efficiently and courteously. Ensuring your organization conveys an image of friendly and knowledgeable staff with every patient encounter.

- All calls should be answered within 3 rings.
- Call transfers should be warm handoffs to ensure no dropped calls and appropriate connection for patients.
- Do not leave patients on hold for extended periods of time and routinely check in and explain to the patient if departmental delays occur in transfer.
- Establish patient call back protocols to ensure timely and effective management of patient needs, these ensure no missed opportunities in revenue.

Scheduling and Appointment Guidelines

Most payor contracts have appointment guidelines built into them for participating providers, ensure that your processes for scheduling allow for timely and compliant scheduling.

- Consider Patient Self Scheduling Options to reduce lift on existing workforce for elective services.
- Schedule Appointments in consecutive blocks and collaborate to ensure efficiencies for the patient.
- Ensure your organization has an appointment reminder system.
- Use waitlisting to mitigate late cancellations and no shows.
- Consider telehealth versus in person care if applicable and appropriate.
- Collect data and ensure verification of information no more than 48 hours in advance of procedure.
- Explore Double booking – cautiously/strategically
- Implement worklist to ensure capture of add on patients, etc. For data reconciliation and accuracy.

Sample Appointment Guidelines

APPOINTMENT AVAILABILITY

The following standards are established regarding appointment availability:

Type of Care	Accessibility Standard*
PRIMARY CARE	
Emergency	Immediately; for services that are not emergencies or urgently needed, but in need of medical attention within one week
Urgent care	Immediately; for services that are not emergencies or urgently needed, but in need of medical attention within one week
Routine	Within 30 days of request
Specialty Care	Within 21 days of request
Specialty Care Referrals	Within 5 days of request
High-Risk or 3rd Trimester Pregnancy	
Emergency	Immediately
Routine	Within 5 days of request

The in-office wait time is less than 15 minutes, except when the provider is unavailable due to an emergency.

The following are behavioral health appointment access guidelines:

Appointment Type	Description	Standard*
Non-life threatening emergency	Behavioral health services for non-life threatening emergencies provided within 6 hours	Within 6 hours
Urgent	Behavioral health services provided within a time frame indicated by behavioral health condition but no later than 24 hours from identification of need	Within 24 hours

Provider Manual (centene.com)

Patient Reminders

Establish Patient Reminder protocols to mitigate no show appointments or late cancels.

- Create a waitlist or a bump list to fill late cancellations.
- Create a daily opening list for appointment slots available and communicate to scheduling.
- Automated or Manual reminder calls should occur at 5 days prior to a scheduled service and again the day prior.
- Confirmation of appointment or cancels within the five-day window can allow for a patient from a waitlist to be given an earlier opportunity. This creates a revenue source for an otherwise loss.
- If patients cancel the day prior, automatically reschedule the patient.
- Create a nurse call list for no shows to determine if care management minutes or virtual telephone encounter can be generated.
- Establish patient appointment protocols of you have not already and ensure patients sign appointment attestation at least once annually.
- Establish a NO Show policy and bill no show visits accordingly.

Pre-Service and Point of Service Collections

Appropriate and Accurate verification of eligibility and benefits will lead to accurate data for the amounts to be collected from the patient either preservice (recommended) or point of service. Prebilling collection of patient responsibility can significantly decrease costs associated with collecting patient balances, while improving uncompensated care at your organization.

- Develop scripting and signage to display your position to your patients in a friendly manner.
- Develop analytics for what should have been received in point of service for collection copayments versus what was and monitor for improvement.
- Develop a follow up worklist for patients whom were unable to pay at the time of service for either collection or charity application to collect balances prior to billing and within your charge lag day parameters.

Pre-Registration

Ideally, the pre-registration process should accomplish improved registration times, better patient flow, decreased expense to collect patient liability and most importantly a higher quality patient experience that can enhance and improve patient retention.

- Ensure preregistration is conducted PRIOR to the visit. The process of preregistration should allow the collection of all of the required patient demographic and payment information into the EMR software. This will reduce the data entry required at check in and improve patient flow.
- Incorporate scripting in pre-registration to collect out of pocket patient liability PRIOR to the patient arriving.
- Consider mailed questionnaires, direct software pre-registration, telephone and in person options to preregister patients for ALL elective services in your organization.
- Create cross functional workflows for collaborating facilities and campus locations.

Registration

Upon arrival to your organization, patient information identified, and a patient record is compiled or updated. It is critical that registration identify all components:

- Obtain and or validate patient demographic and emergency contact information.

  Questions like "Is everything still the same?" or "Has anything changed?" are unacceptable practices. Yet patients continue to experience these scenarios every day and organizations have cash flow impacts because of it. Something as simple as a letter could change in and Insurance subscriber ID. Note: Some of the information as described below may be obtained through Pre-Registration processes and in this instance, it should be validated.

- Identify Reason for visit, which also includes identifying the correct third-party liability and necessary forms. I.e., Accident
- Obtain accurate insurance and/or payment information.
- Accurately input insurance plan networks and their respective insurance order into the EMR. This includes network, mailing address, phone numbers, all plan identification numbers, correct subscribers, prefixes, suffixes, subscriber DOB, SSN and employer.
- Family physician or Primary Care Provider for appropriate clinical continuation/notification.
- Obtain copayment, coinsurance and/or deductible
- Obtain and maintain appropriate signatures for treatment and release of information
- Describe and/or provide the patient with Patient Rights, Notice of Privacy Practices, Surprise Billing Disclosures, etc.

Identification of Preventative/Service Needs

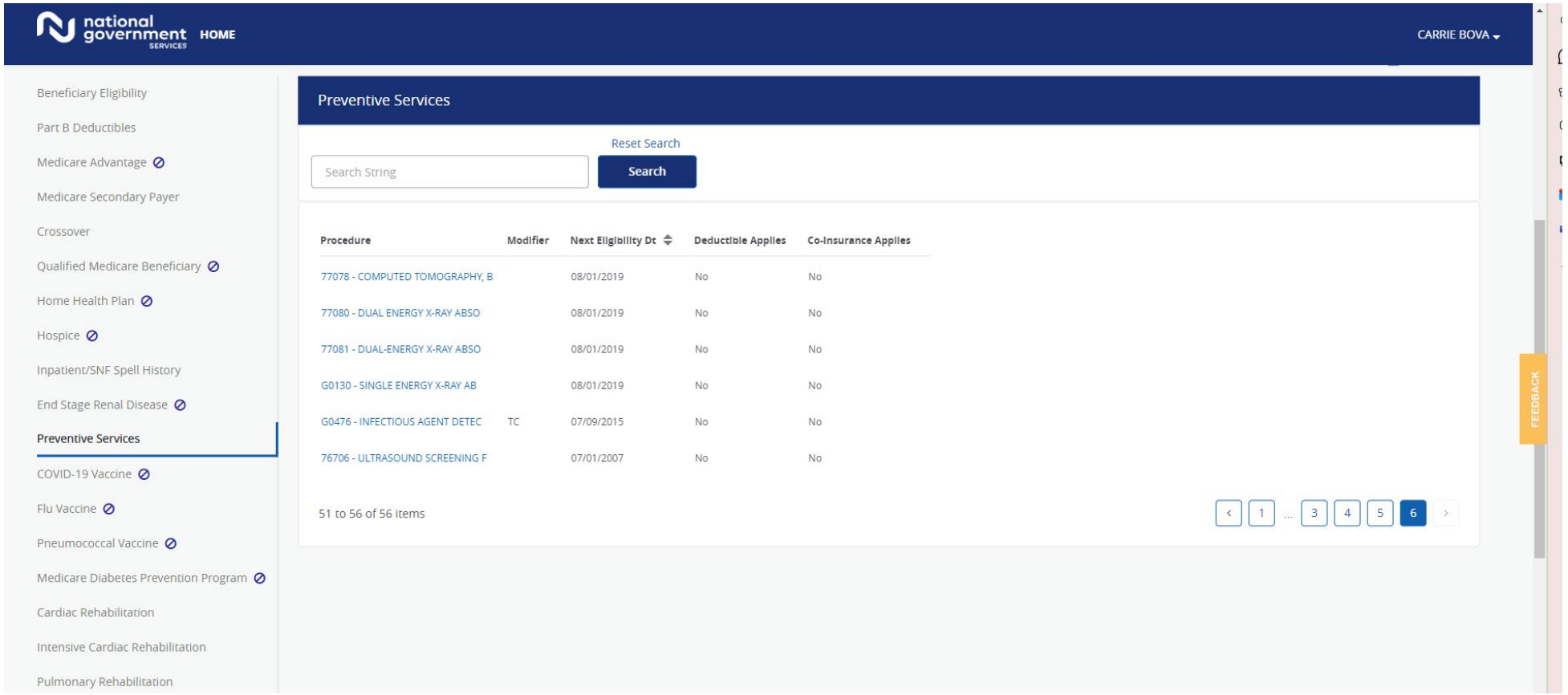
Medicare includes information relating to the eligibility for preventative services both for traditional Medicare but also for Medicare Advantage Enrollees. Many Managed Care plans also provide reports for patients empaneled to your practice with service needs.

- Start with your Medicare patients. Communicate Preventative/Service needs to nursing staff. The coordination of these services counts as Care Management minutes.
- Reach out to Managed Care payor representatives and establish routine delivery and accountability for monitoring your patient empanelment.
- Establish routine reports and assignments to generate revenue for your practice and organization.

Look at your patients schedules in the next weeks that are eligible for Medicare and run preventative service eligibility. Communicate and realize up to $2000 in ancillary revenue per patient. Preventative services have no out of pocket liability for your patients in most scenarios.

Identification of Preventative/Service Needs

In reviewing one patient, six pages of eligible preventative service needs were identified that totaled $3166.81 in reimbursement should the patient receive all services eligible.



Preventative Services and Front-End Processes

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					Quality Management of a Patient
71271 - LOW DOSE CT SCAN OF CH		1/1/2021	No	No	$ 139.01
76706 - ULTRASOUND SCREENING F		7/1/2007	No	No	$ 104.10
76977 - ULTRASOUND MEASUREMENT		8/1/2019	No	No	$ 6.71
77078 - COMPUTED TOMOGRAPHY, B		8/1/2019	No	No	$ 101.89
77080 - DUAL ENERGY X-RAY ABSO		8/1/2019	No	No	$ 36.96
77081 - DUAL-ENERGY X-RAY ABSO		8/1/2019	No	No	$ 30.51
80061 - BLOOD TEST, LIPIDS (CH		8/1/2019	No	No	$ 13.39
81528 - GENE ANALYSIS (COLOREC	TC	8/1/2019	No	No	$ 508.87
82270 - STOOL ANALYSIS FOR BLO		8/1/2019	No	No	$ 4.38
82465 - CHOLESTEROL, SERUM OR		8/1/2019	No	No	$ 4.35
82947 - GLUCOSE; QUANTITATIVE,		8/1/2019	No	No	$ 3.93
82950- GLUCOSE; POST GLUCOSE D		8/1/2019	No	No	$ 4.75
82951 - BLOOD GLUCOSE (SUGAR)		8/1/2019	No	No	$ 12.87
83718 - LIPOPROTEIN, DIRECT ME		8/1/2019	No	No	$ 8.19
84478 - TRIGLYCERIDES		8/1/2019	No	No	$ 5.74
G0101 - CERVICAL OR VAGINAL CA	TC	8/1/2019	No	No	$ 37.97
G0101 - CERVICAL OR VAGINAL CA	26	9/1/2022	No	No	$ 37.97
G0104 - COLORECTAL CANCER SCRE		8/1/2019	No	No	$ 180.92
G0105 - COLORECTAL CANCER SCRE		8/1/2019	No	No	$ 331.05
G0106 - COLORECTAL CANCER SCRE		8/1/2019	No	Yes	$ 218.52
G0117 - GLAUCOMA SCREENING FOR		8/1/2019	Yes	Yes	$ 61.56
G0118 - GLAUCOMA SCREENING FOR		8/1/2019	Yes	Yes	$ 40.53
G0120 - COLORECTAL CANCER SCRE		8/1/2019	No	Yes	$ 159.55
G0121 - COLORECTAL CANCER SCRE		8/1/2019	No	No	$ 331.30
G0123 - SCREENING CYTOPATHOLOG	26	8/1/2019	No	No	$ 20.26
G0123 - SCREENING CYTOPATHOLOG	TC	9/1/2022	No	No	$ 20.26
G0130 - SINGLE ENERGY X-RAY AB		8/1/2019	No	No	$ 34.73
G0143 - SCREENING CYTOPATHOLOG	26	8/1/2019	No	No	$ 27.05

- Reviewing this one patient, there is potential for Revenue generation with minimal lift of approximately $3000.00 + based on Locality Fee schedule allowances. Also, quality and comprehensive patient management is occurring to help ensure better health outcomes in the future with minimal or no patient cost share.
- This is a real patient, and these are real Medicare allowances.
- Imagine a practice with 100 active Medicare patients even eligible for half of the services indicated. There is a potential revenue gain of approx. $20,000 per 100 patients on average.

Coordination Of Benefits

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Coordination of Benefits applies to any person who has coverage from more than one insurance plan. There are specific rules that patient access representatives need to be aware of to ensure prompt submission and payment of claims, through reconciliation of an encounter.

- Birthday Rule - Insurance companies use the birthday rule to decide primary coverage for dependents that may be covered by more than one subscriber. Most often this rule affects dependent children. The subscriber whose birthday, month, and day only, falls first in a calendar year supplies the primary coverage for the dependent and the other coverage is secondary.
- Medicare beneficiary Hospice Rules - Hospice election is consistently selected by Medicare beneficiaries for management of a terminal condition. However, hospice patients often receive care that is unrelated to the condition that they are enrolled in hospice for. Ensuring that this is clearly defined and communicated to receive payment for non-hospice care is crucial. A modifier GW can be applied to ensure payment is made for the service.
- Medicare MSPQ(Medicare Secondary Payor Questionnaire). Often Medicare eligible beneficiaries can be covered under a spouse. Completing the MSPQ is critical in finding the proper coverage order.
- Worker's Compensation – Offer compensation coverage is limited to covered diagnosis. Ensuring correct information relating to the injury and if services are covered is critical to prompt payment. Ensure processes are in place to confirm covered dx and treatment for injury as well as communication with claims adjuster is imperative.
- Medicaid - Medicaid is always a payor of last resort and much like Medicare, most Medicaid plans have more information relating to coordination of benefits. Accounts must be registered accurately with the correct order. Sometimes the Medicaid System is not updated, and other health insurance is identified as primary. This insurance must be reflected as primary for Medicaid claims to pay even of the coverage is inactive.

Financial Clearance

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Financial clearance is indicative of the likelihood of payment for services. This is inclusive of precertification, authorization, medical necessity, and benefit determination.

- **Benefit Determination**- Benefit determination is the process by which service information is matched with the individual product and benefit information on the subscriber's certificate of coverage. The certificate of coverage for each plan varies and, in some cases, the health plan may have another subsidiary for certain services. Ensuring that the information is being given and input into the EMR based upon the individual benefit coverage is vital to reducing denials and receiving correct reimbursement.
- **Beneficiary Notice Initiatives** - Advance Beneficiary Notices and Medical Necessity Components are critical tasks for Patient Access. If a patient presents for a lab test or other services that it not medically supported by the physician order, patient access staff must deliver an ABN as required by Medicare. Scripting should be supplied as to not dissuade patients from receiving the exam. Patient Access Departments that effectively manage ABN issuance and medical necessity requirements have reduced Medical Necessity Denials by 38% nationwide. Additionally, cash realization is much timelier than those who later query provider offices. Consider a medical necessity review process daily for incoming ancillary orders and collaborate with referring/servicing departments to address services that do not meet medical necessity at the time of order, rather than post service. Other Beneficiary Notices such as the Important Message from Medicare, MOON notice, HINN notices should also be easily accessible. Often Patient Access can be the second look as some of these functions are performed in Utilization Review, however there are critical elements to billing that can be entered and confirmed with the support of Patient Access to ensure compliance and show revenue risk.
- **Authorization** - Authorization is a payor requirement to obtain approval of care or service for payment to be given. Authorization grids by health plan change monthly. Establishing protocols to not only obtain but reconcile authorizations post service can save thousands in lost revenue. Find in you EMR where authorization can be input to ensure that it flows directly for claim submission to realize cash more quickly and prevent unnecessary claim denials.

Referral Management

Appropriate referral management and communication can enhance ancillary patient service revenue and enhance or build care management revenues.

- Establish preventative service communication to ensure that you are meeting value-based care requirements.
- Communicate with nursing/provider staff to ensure preventative eligibility for empanelment is addressed.
- Review payor-based noncompliance reports and schedule patients accordingly.
- Educate on system service offerings and encourage scheduling through system.
- Develop a checkout process and collaborative campus scheduling.
- Use checkout and referral management to enroll patients in Care Management Programs.

Establish Check Out Protocols

Going beyond the initial pre-registration/check in processes to ensure patients are receiving the care they need, promoting that it be completed by your organization and using check out as a second attempt to review for charity or collect balances can really have a budgetary impact on your organization.

- Establish check out protocols to improve patient compliance and experience for ordered services while driving them to your organization can have significant budgetary impact.
- Consider registering patients or pre-registration of patients at check-out to facilitate more patient friendly process.
- Provide Charity Care application and outstanding balance information at check out so patients feel well informed and/or provide you with additional information needs such as insurance company follow-up, identification of additional insurance coverages or timely application and completion of charity.

Financial Counseling

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Financial counselors assist patients in understanding their insurance coverage and benefits and how those benefits can and will apply to services the patient receives. Financial Counseling roles and expectations have significantly increased since the implementation of Pricing Transparency regulations.

- **90-day lookback** – Often Medicaid coverage can be determined based upon facilitated enrollment. When a patient becomes enrolled in a Medicaid Managed Care product, often traditional Medicaid plans will cover bills up to 90 days back. So often this is not communicated or addressed and patients eligible for Medicaid are billed. Implement a 90-day lookback review on self-pay registration and patients who recently became enrolled in Medicaid managed care. This process converts a dead claim to a payment source and ensures balance billing requirements for Medicaid eligible patients.
- **Bad Debt Review** – Ensure patient access staff are thorough and competent with Bad Debt reviews. This normally occurs in Financial Counseling offices for best results. Ensure Medicare Bad Debt write-off processes are built with audit forms. This ensures compliance with Medicare Bad Debt 2020 provisions, increases severe debt realized on the cost report and autocompletes the Cost Report S10 worksheet to eliminate lift and costs associated with this for cost report filing.
- **Charity/Self Pay Management–** Charity care effectively managed by financial counseling can promote effective management and reduction in AR days. Consider partnering with a health plan to offer facilitated enrollment and create a workflow that notifies health plan with patient consent, so they are effectively able to enroll self-pay patients into coverage. This gets the patient quality care that is needed, reduces overutilization of the ED for non- emergent services and effectively converts self-pay balances into payment sources now and in the future.

Questions

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Appropriately addressing the front end can lead to multiple revenue enhancements that may not otherwise be realized.

From decreased expenses, new enrolled care management and ancillary service revenue generated, Patient Access and Front- End staff are integral to an organization's financial success.

Carrie Bova, Senior Consultant
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ORH Announcements

Aug. 24, 12 p.m. – 1:30 p.m. | Community Conversations: Supporting Oregon's Critical Access Hospitals and Rural Health Clinics (*register here*)
Learn about the programs and assistance the Oregon Office of Rural Health support Oregon's Rural Health Clinics and Critical Access Hospitals.

Aug. 31, 12 p.m. - 1:00 p.m. | The No Surprises Act: Revenue Protections and Transactional Compliance (*register here*)
Pricing transparency regulations have been in place since 2020, yet a vast majority of hospitals are still noncompliant. This presentation will provide strategies to employ improved eligibility and coverage estimates, providing patient estimation and good faith estimates, and improving precertification and authorization issues to prevent inaccurate balance billing and ensure rural hospitals meet regulatory requirements to mitigate potential financial penalties.

October 11-13, Sunriver, OR | 40th Annual Oregon Rural Health Conference
(*register here*)

ORH Needs Your Rural Health Story!
We are looking for stories from your community to highlight at the ORH Conference. Click the "Tell Us Your Story" link to submit the great stories that have contributed to your community's health over the last 40 years.

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