Front-End Revenue Cycle Improvement: Patient Registration

National Rural Health Resource Center
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CPAs & Advisors

Agenda

1. What is Patient Registration?
2. Overview of Patient Access Pre-Arrival Functions
3. Patient Registration and Pre-Arrival Performance Measurement
4. Closing and Q&A

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Patient Registration

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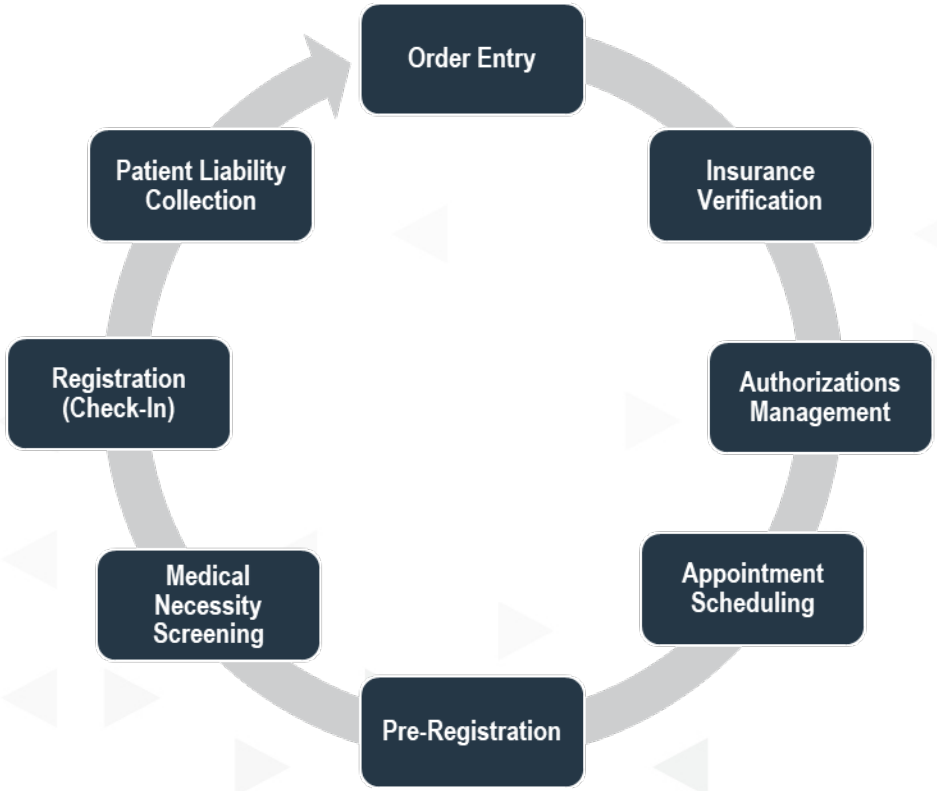
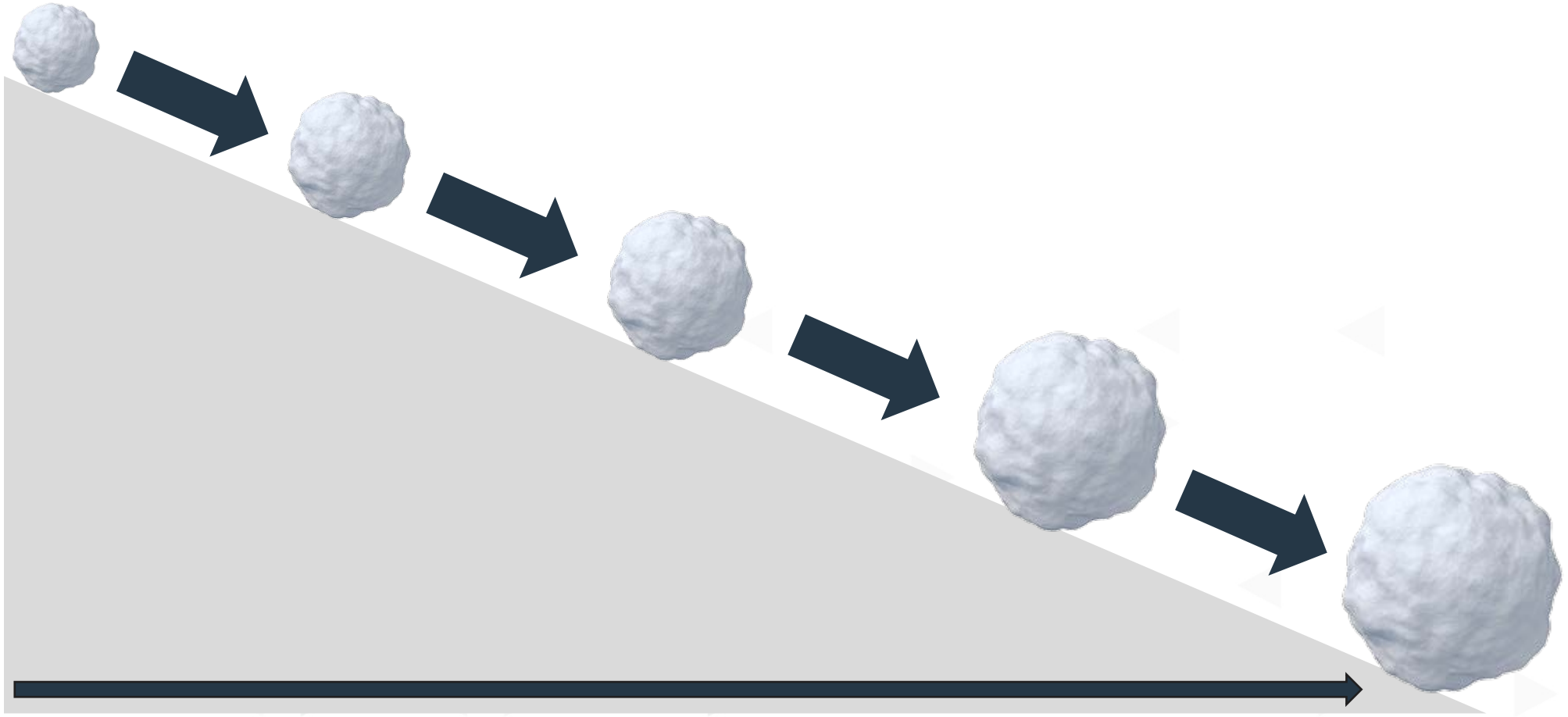
WHAT IS PATIENT REGISTRATION?

Patient Registration: All processes related to the activation of an encounter/account including a review of demographic, insurance, and other patient related information.



WHY IS PATIENT REGISTRATION IMPORTANT?



WHY IS PATIENT REGISTRATION IMPORTANT? (CONTINUED)

- The UB-04 claim form used in billing for hospitals and other institutional providers is made up of **81 different data fields** called "form locators" and Patient Access is accountable for obtaining >60% of them.

Primary Categories of UB-04
Provider and Patient Information (Form Locators 1-41)
Services Provided to the Patient (Form Locators 42-49)
Patient Insurance Information (Form Locators 50-65)
Diagnosis, procedure, and physician information (Form Locators 66-81)

Examples of Some Required Data Fields for UB-04 Claim Form:

- Patient Name
- Age
- Sex
- Date of Birth
- Insured Name
- Patient's Relationship to Insured
- Insured Member ID
- Insured Group Number
- Date of Service
- Mailing Address
- Provider Name, Address and Telephone number

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Patient Access Pre-Arrival Functions

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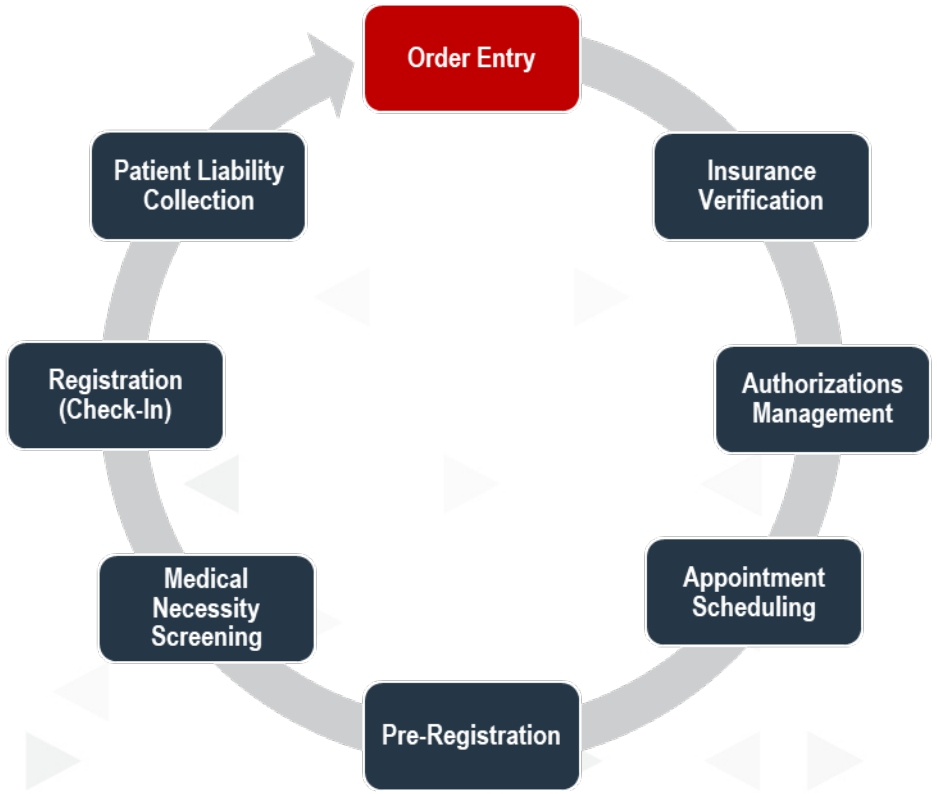
ORDER ENTRY: BEST PRACTICES



- **Communicate expectations of timely provider order entry** and establish guidance to complete at the end of every encounter and avoid delaying to the end of a shift or day.
- **Establish policy that requires a physician signature on an order** to confirm appointment booking detail with patients.
- **Implement provider options for priority indicators such as "Routine" and "STAT/Urgent"** to develop dedicated processes to expedite scheduling and when required bypass built-in gatekeepers to flag potential plan authorization requirements.
- **Develop order templates that accommodate a description of the service and the corresponding CPT code(s)** to assist downstream efforts around patient liability price estimation.

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INSURANCE VERIFICATION: BEST PRACTICES

- Implement a check of insurance eligibility, benefits verification, and coordination of benefits each time an appointment is scheduled and each time a patient arrives to check-in for a service.
- Communicate expectations to staff that they should leverage ALL available options to verify insurance including electronic eligibility software, payer websites, and telephonic outreach, if necessary.
- Implement "batch launch" eligibility checks for all scheduled appointments to greatly improve the number of insurance plans verified. Errors that result from the "batch launch" can be populated as an exception-based worklist to be worked by staff in advance of the service.
- Publish internal guides with screenshots of accepted insurance cards can assist staff with not only verifying the insurance correctly, but also ensuring the patient is added to the correct financial class.

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AUTHORIZATIONS MANAGEMENT: BEST PRACTICES

- Develop an authorization mapping dictionary that crosswalks insurance plans, CPT codes, and authorization requirements. The dictionary should be maintained and updated continuously as plan changes are identified.
- Establish policy around authorizations management that is specific and details exception scenarios for scheduling without authorization (EX: STAT/Urgent priority).
- Implement account checks on encounters for missing authorizations for denial high risk areas such as inpatient admissions and outpatient surgery in order to ensure authorization is on-file prior to claim submission.
- Trend and analyze missing and/or invalid authorization denials to identify any potential changes to plan requirements (EX: Expansion of authorization requirement across additional sites of service).

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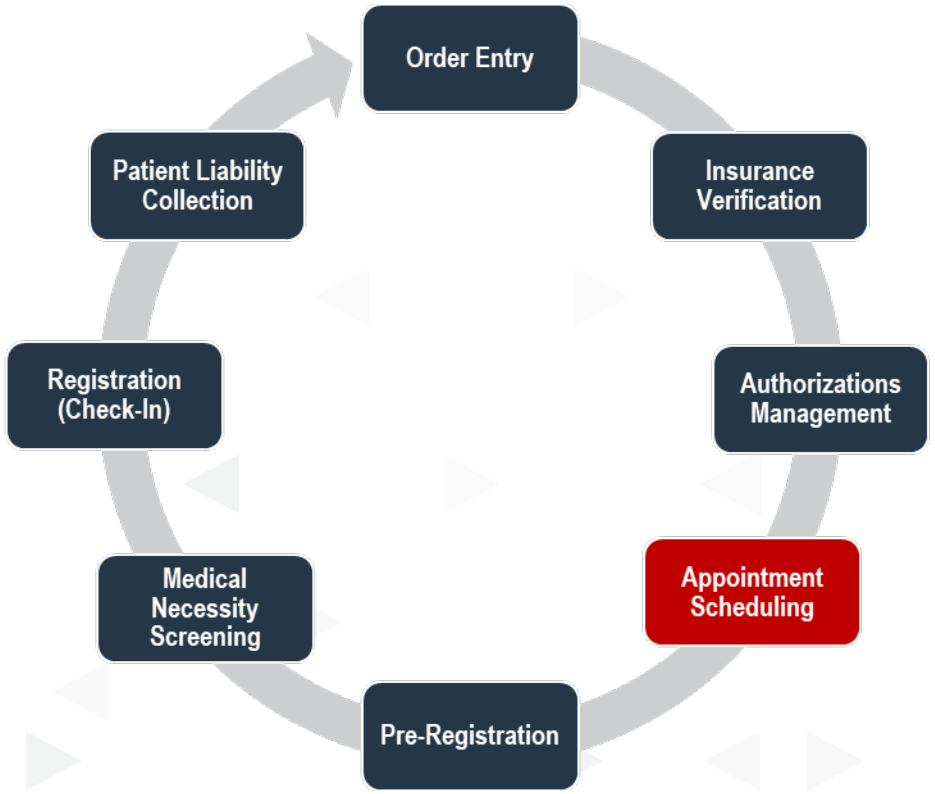
APPOINTMENT SCHEDULING: BEST PRACTICES



- Implement minimum scheduling requirements for "Routine" priority hospital outpatient encounters:
  - Signed provider order on-file
  - Insurance verification or self-pay deposit is collected.
  - Any plan authorization requirements have been met.
- Establish policy allowing "Urgent" priority hospital outpatient encounters to be scheduled without delay; however, any authorizations required need to be initiated with the payer prior to end of day on the date of service.
- Establish policy requiring insurance eligibility verification, collection of self-pay deposit, or financial assistance approval where applicable, in order to be scheduled.
- Trend and monitor appointment realization which is calculated by dividing the number of appointments rendered over the appointments scheduled over a given period.

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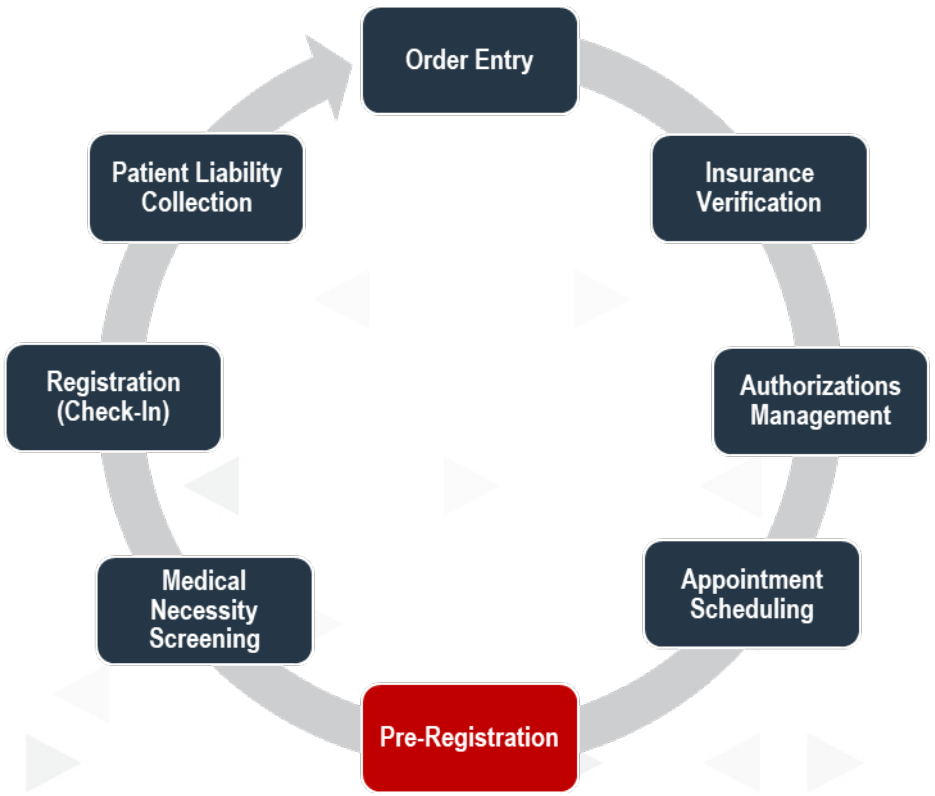
PRE-REGISTRATION: BEST PRACTICES



- Establish Pre-Registration productivity tracking and monitor performance against a best practice goal of >94% of scheduled hospital outpatient encounters pre-registered prior to service.
- Implement robust staff quality audits and review patient accounts to ensure accuracy and completeness of pre-registration process.
- Develop price estimates for all hospital outpatient services and ask for a minimum deposit for both insured and uninsured patients.
- Position Pre-Registration staff to function as a coordinated patient access "safety net" to ensure all scheduled patients are financially cleared for their upcoming services (EX: Authorization on-file, pre-care deposit obtained, financial assistance approved).

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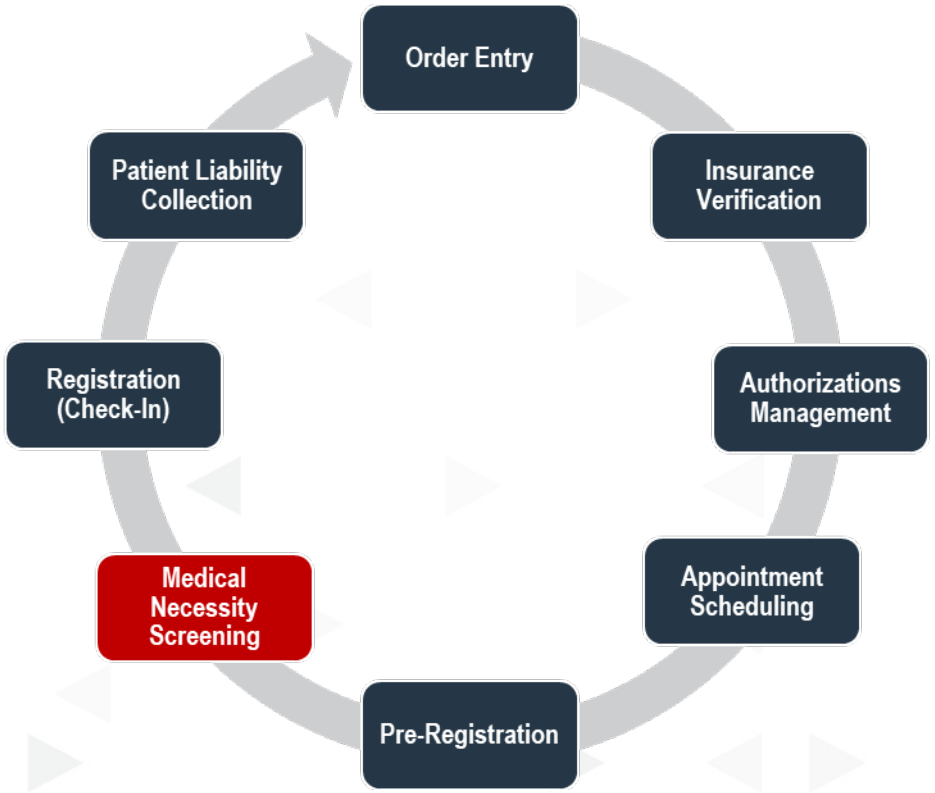
MEDICAL NECESSITY SCREENING: BEST PRACTICES



- Develop a financial clearance process that ensures a check of medical necessity prior to service with dedicated efforts to ensure they are obtained for affiliated and non-affiliated providers performing hospital services.
- Leverage Utilization Review and Case Management to assist in ensuring medical necessity screenings are conducted for patients in the inpatient setting.
- Implement rescheduling protocols and assign accountability for all appeals for services that are initially denied by the payer due to medical necessity.

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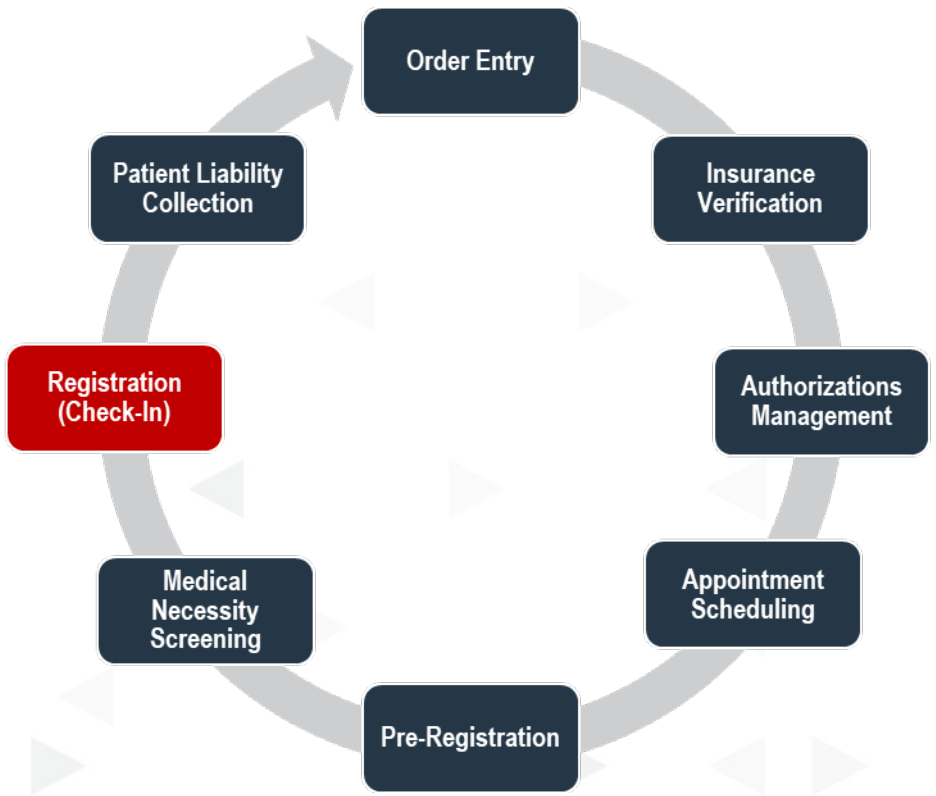
REGISTRATION (CHECK-IN): BEST PRACTICES



- Develop comprehensive registration processes for all hospital encounters to include outpatient, inpatient and emergency services.
- Direct Registration staff to follow-up on price estimates previously created and if no collection was made to ask for a minimum deposit for both insured and uninsured patients.
- Implement robust staff quality audits and review patient accounts to ensure accuracy and completeness of registration (check-in) process.
- Establish a financial clearance review at check-in which requires a check of insurance eligibility, benefits verification, and coordination of benefits.

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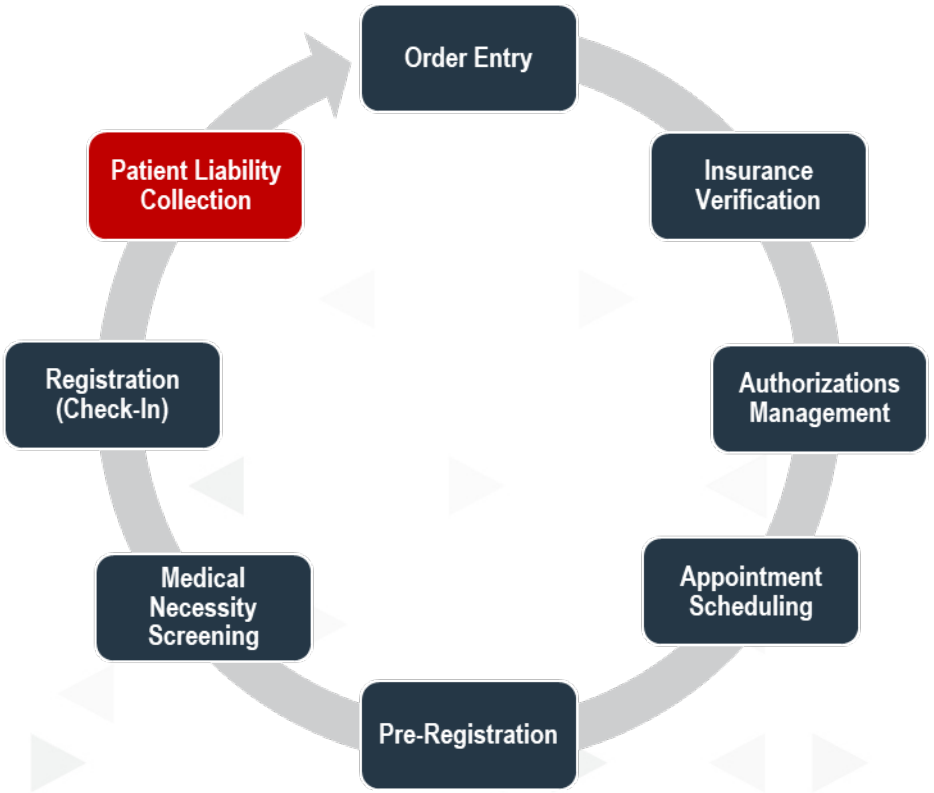
PATIENT LIABILITY COLLECTION: BEST PRACTICES



- **Phase-in pre-care deposit requirements with price estimates to support collection asks** initially beginning with a narrow set of outpatient services such as advanced imaging, endoscopies, and diagnostic colonoscopies.
- **Ensure all registration points of the hospital inclusive of surgery centers, imaging centers, and sleep labs, among others** have the proper system access and training to facilitate point of service collections.
- **Develop conservative and reasonable flat-fee surgery deposits and require patients to pay** deposits as a pre-condition of elective service.
- **Trend and monitor patient cash collection efforts** such as at the point of service and through the pre-registration process to identify areas of improvement.

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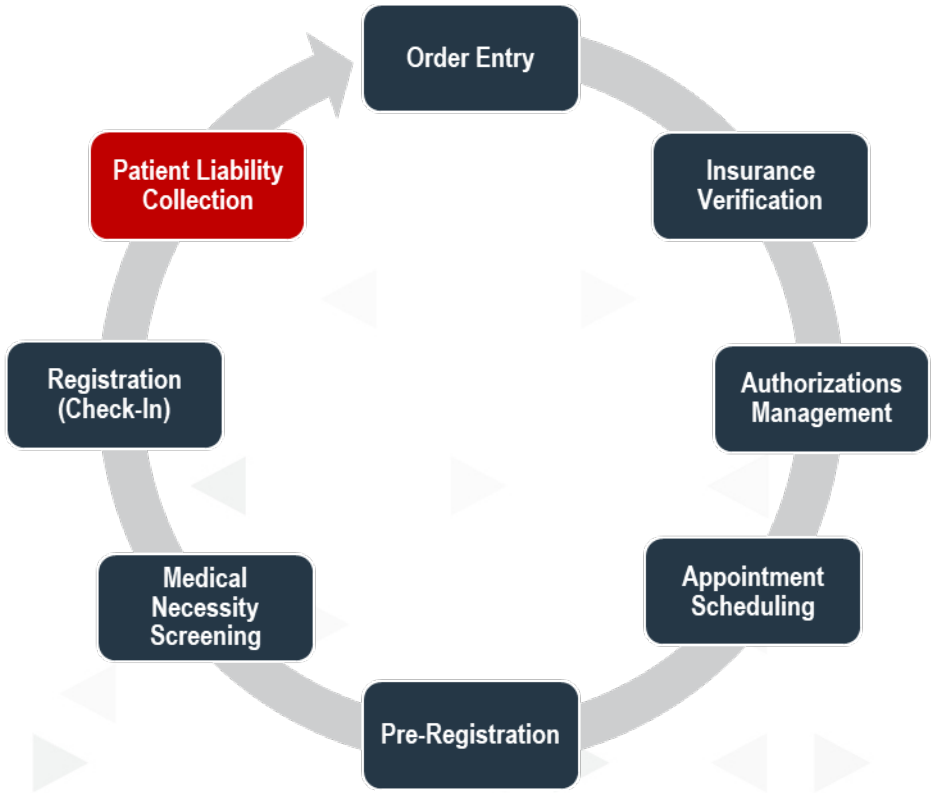
PATIENT LIABILITY COLLECTION (FINANCIAL COUNSELING): BEST PRACTICES



- Publish clearly and conspicuously your organization's Financial Assistance Policy (FAP) and implement process that connects patients to Financial Counselors during both pre-registration and registration (check-in).
- Establish self-pay uninsured discounts and direct staff to offer them to uninsured patients who do not qualify for financial assistance.
- Implement targeted COBRA premium assistance programs to ensure insured patients presenting high financial risk such as in oncology and infusion services do not lapse coverage while receiving their extended care.

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Patient Access Performance Measurement

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PATIENT ACCESS STAFF QUALITY AUDIT SCORECARD

Staff QA Criteria	
Registration Accuracy	Criteria
Patient Demographics and Documentation	1. Information accurately transposed for all required fields. 2. Demographic information is not missing on account. 3. Insurance card is scanned to the account. 4. Consent forms and admissions documents are completed.
Patient and Guarantor Address	1. Completeness of patient address. 2. Completeness of guarantor address. 3. Comprehensive matching of each element of the address.
Patient and Subsciber Relationship	1. Patient and subscriber relationship is referenced on account. 2. Patient and subscriber relationship is accurate on account [emphasis on the correct sequential relationship reference].
MSPQ	1. MSPQ attempted on all Medicare patients. 2. MSPQ not attempted on non-Medicare patients. 3. MSPQ completed in full [emphasis on no missing answers to required questions].
Occurrence Codes	1. Appropriate listing of occurrence codes when required.
Insurance and Benefit Verification	Criteria
Eligibility Verification	1. Insurance was launched on account. 2. Timestamp of date/time verification reflected on account. 3. Copy of 271 response from Passport/OneSource listed in comments field of account.
Meditech Insurance Assignment	1. Correct interpretation of eligibility response when assigning insurance in Meditech. 2. Assignment of self-pay for all eligibility responses indicating insurance terminated or does not cover the service being performed.
Collection Action	Criteria
Collection Attempt	1. Co-pay collection attempt result listed in comments field of account regardless if the patient agreed to payment at point of service. 2. Accounting of 20% prompt pay discount for all payments taken on prior balances [non-co-pay collections].
Payment Posting Accuracy	1. Payments posted at the point of service completed with one of three transaction codes: PCASH, PCHECK, PSP. 2. Payments posted at the point of service are applied to the correct account.

Key Features of a Quality Audit Scorecard:

- Standardized questions for all patient accounts reviewed.
- Minimum number of patient accounts should be reviewed each audit period.
- Identify department-level trends and scan for new opportunities to include in audit.

INSURANCE VERIFICATION RATE

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Insurance Verification Rate	How effective the organization is at verifying insurance eligibility	Total Scheduled Encounters with Eligibility Verified / Total Scheduled Encounters	Good: 80%	Better: 90%	Best: 98%

1. Benchmark metrics provided by National Association of Healthcare Access Management (NAHAM) Access Keys 4.0

PRE-REGISTRATION RATE

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Pre-Registration Rate	How effective the organization is at pre-registering scheduled encounters	Total Scheduled Encounters Pre-Registered / Total Scheduled Encounters Available to Pre-Register	Good: 80%	Better: 90%	Best: 95%

1. Benchmark metrics provided by National Association of Healthcare Access Management (NAHAM) Access Keys 4.0

POINT OF SERVICE COLLECTIONS AS A % OF PATIENT CASH

Metric Name	What is it measuring?	Calculation	Benchmark[1]		
Point of Service Collections as a % of Patient Cash	How effective the organization is at collecting at the point of service	Point of Service Collections / Total Patient Cash	Good: 30%	Better: 40%	Best: 50%

1. Benchmark metrics provided by National Association of Healthcare Access Management (NAHAM) Access Keys 4.0

SAMPLE PATIENT ACCESS DENIAL DASHBOARD

Key Features of a Patient Access Denial Dashboard:

- Establish patient access-related denial categories.
- Trend patient access-related denials month over month.
- Set baselines and establish goals.

Patient Access Denial Total $: Monthly Trending (IP, OP):

Denial Group	Rolling 3 Mo Avg: Difference from Baseline	Current Month: Difference from Baseline	Baseline: 10/19-3/20	Trending	202007	202008	202009	202010	202011	202012
Authorization IP	(615,986)	(708,002)	1,085,552		762,225	1,589,901	503,903	965,191	377,550	65,957
Authorization OP	(82,050)	(24,562)	475,407		171,378	375,212	308,665	662,667	450,846	66,560
Eligibility IP	71,532	(251,765)	270,814		299,682	601,362	197,647	128,105	19,049	879,885
Eligibility OP	(120,031)	(258,694)	542,435		646,484	374,984	551,621	574,856	283,742	408,616
Registration IP	(87,444)	(82,373)	133,843		11,720	212,012	406,116	69,821	51,470	17,907
Registration OP	(89,378)	(39,181)	167,380		49,477	49,662	149,201	100,588	128,199	5,221

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SAMPLE POINT OF SERVICE COLLECTIONS DASHBOARD

Key Features of a Point of Service Collections Dashboard:

- Establish point of service collections by location.
- Trend point of service collections month over month.
- Display point of service collections by staff to target education efforts.

Point of Service Collections Total $: Monthly Trending

Sum of Amount	Payment Month				
Visit Loc	201910	201911	201912	202001	202002
*Emergency Room	$ 22,698.99	$ 19,077.09	$ 20,394.00	$ 17,121.33	$ 17,284.63
Cath Lab		$ 500.00		$ 1,298.02	$ 1,685.45
Diagnostic & Surgical Center	$ 4,629.64	$ 1,146.56	$ 1,430.00	$ 4,632.81	$ 3,481.76

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WRAP-UP: KEY INGREDIENTS OF PATIENT ACCESS TRANSFORMATION

- Secure buy-in support from the top down in the organization.
- Invest in education and align processes to create a Culture of Financial Clearance.
- Define metrics for success, capture data for monitoring, and make performance results highly visible.
- Reward and celebrate employees for high performance.

Thank You!

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Questions?
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POLLING QUESTION (PRE AND POST PRESENTATION)

Question: Patient Access is responsible for over _____ % of the claim fields on a UB-04?

A. 20%
B. 40%
C. 60% (Correct Answer)
D. 80%