FINDING THE MONEY:

Turning Transactions Compliance into Cash

March 2004

John Thompson, Director
Tom Grove, Vice President
OUR DISCUSSION TODAY

- Realizing savings from transactions standards
- Building block: The Pre-registration Model
- Implementing the 270/271 in the pre-registration environment
- Implementing the 278 transaction
- Implementing the 276/277 transactions
FINDING THE MONEY
TRANSACTION STANDARDS

- Forecasted savings ranging from $1 Billion to $4 Billion
  - Increased staff efficiency through increased automation
  - Vendor application changes
  - Business process changes
  - Substantial changes in processes and staff competencies throughout the revenue cycle
TRANSACTION STANDARDS

• Revenue Cycle Departments
  – Changes in organization structure and staffing
  – Increased automation
  – Staff re-alignment
  – Improved data quality
  – Reduced write-offs
TRANSACTION STANDARDS

• Transactions in the Revenue Cycle
  – Admitting, Registration and Authorization
    • Eligibility, coverage or benefit inquiry (270)
    • Payer response (271)
    • Required prior authorization from the payer (278)
  – Billing
    • Healthcare claim (837)
  – Follow-Up
    • Claim status (276)
    • Response (277)
  – Cash Posting
    • Claim payment/advice (835)
THE PRE-REGISTRATION MODEL

“It’s Not Just About Patient Flow Anymore!”
THE PRE-REGISTRATION MODEL

• A well developed “pre-encounter” program is the key to tapping TCS Return on Investment (ROI)

• Pre-encounter activities include:
  – Resource scheduling
  – Payer authorization
  – Benefit verification
  – Pre-registration
THE IMPORTANCE OF PRE-REGISTRATION

• Pre-registration is no longer simply a value-added service performed to improve patient flow. Today, it is the critical activity that enables the efficient operation of the total revenue cycle.
THE IMPORTANCE OF PRE-REGISTRATION

• “Research has found that where there are low levels of pre-registration, gross days outstanding (GDRO) is higher.”

WHY?

• By pre-registering patients, organizations can:
  – Gain the lead time needed to obtain insurance benefits prior to an encounter
  – Inform patients of their financial obligations prior to an encounter
  – Increase up-front collections
WHY?

• By pre-registering patients, organizations can:
  – Schedule self-pay patients for counseling services
  – Reduce denials of non-covered services
  – Improve customer satisfaction
BENEFITS

• Using today’s technology to leverage the benefits of HIPAA, effective organizations can:
  – Improve accounts receivable
  – Reduce denials
  – Enhance data integrity
  – Improve FTE utilization
THE “TREATMENT” APPROACH

• Ineffective organizations tend to use a “treatment” approach to manage encounter issues
  – Resources are deployed to manage financial issues on the date of service

• Goals:
  – Maintain patient flow and low wait times
  – Get the authorizations that we can
  – Have the billing staff figure out payment issues and bill the patient after the encounter
“TREATMENT” APPROACH
RESULTS

• Practitioners of this approach generally experience mixed results:
  – Patient flow and wait times may be unpredictable. Over-staffing and under-staffing are common.
  – Patients are seen without approvals.
  – Patient may neglect to pay for services after the fact. Bad debt and write-offs mount.
THE “TREATMENT” APPROACH

• It is interesting to note that many practitioners of the “treatment” approach actually *schedule* patients in advance of encounters, yet they do not use this “golden opportunity” to pre-register these patients.
THE “TREATMENT” APPROACH

• Although these organizations will benefit from implementing HIPAA transactions, they will still tend to experience avoidable denials, up-front collection difficulties and the customer dissatisfaction associated with these issues.
A “PREVENTION” APPROACH

• Using a “prevention” approach, effective organizations use scarce resources to **prevent** denials by pre-registering patients.

• Goals:
  – Secure approvals and authorizations
  – Explain benefits vs. charges
  – Reduce or eliminate tasks on the date of the encounter
  – Reduce or eliminate bad encounters
"PREVENTION" APPROACH
RESULTS

• “Prevention” approach practitioners more often get the following results:
  – Prior authorization of scheduled encounters
  – Out-of-pocket payment prior to or no later than the date of service
  – 1 to 2 minute “check-in” encounters replace lengthy registration sessions
  – Advance payment arrangements for elective self-pay encounters
"PREVENTION" APPROACH
RESULTS

• “Prevention” approach practitioners are also positioned for an additional major benefit:
  – They are positioned to fully benefit from the administrative simplification benefits of HIPAA through the effective use of pre-registration practices
HOW DO WE GET THERE?

• Many organizations have the FTEs (full-time equivalent employees) to do this now, but they are deployed inefficiently at the point of the patient encounter.

• One Northern Virginia client realized that a change in focus was required.
THE “PARADIGM SHIFT”

• Their focus shifted from “How do we get more resources to manage our hectic encounters?” to a realization of “As goes pre-registration, so goes the revenue cycle.”
ONE EXAMPLE

• 75% of encounter-based FTEs were shifted to the central scheduling unit with a new mission:
  – To collect all registration information during the scheduling encounter
ONE EXAMPLE

• A financial screening group was then created to:
  – Obtain insurance benefits
  – Collect managed care referral
  – Explain benefits and payment requirements
THE RESULTS

• Without adding FTEs, the organization experienced the following results:
  – Denials decreased
  – Waiting time decreased from 24 minutes to 3 minutes
  – Up-front collections increased
THE PRE-ENCOUNTER MODEL, FULLY IMPLEMENTED
IMPLEMENTING THE 270/271
270/271

- The 270 and 271 transactions will allow you to request and to receive authorization and benefit information from your payers.
- The transactions may be conducted in advance of or at the time of service.
To maximize ROI and patient satisfaction, you must pre-register patients in advance of encounters.

Benefits:
- Improved lead time to obtain insurance benefits prior to the encounter
- Better communication and management of patient expectations for the encounter
- No patient waiting time for registration/pre-certification at the encounter
IMPACT

• 20% FTE savings
• FTEs reassigned to pre-registration, reducing bad debt write-offs and write-offs due to lack of authorization
BEST IMPLEMENTATION STRATEGY

• This transaction is easy to implement as a web-based transaction
  – Purchase blocks of transactions from a vendor

• More effective is an integrated solution with your HIS
  – Saves staff time
  – Avoids errors
GRADUATE LEVEL STRATEGY

• Combine scheduling, pre-registration and financial counseling in one phone call
  – Conduct the 270/271 transaction in real time, when the patient calls for scheduling
  – Inform the patient of co-pays and past balances, and expect payment at time of service
NON-SCHEDULED PATIENTS

• Most non-scheduled patients arrive in the emergency department
• A good 270/271 process is very fast
• You can do eligibility, get co-pay data, and be ready for point-of-service collection by a discharge counselor
IMPLEMENTING THE 278
• If your organization engages in revenue cycle “best practices,” you pre-register at least 90% of elective encounters.

• Use the lead time to request eligibility and benefit information and (currently) make seemingly endless calls to payers and providers to request referrals and authorizations.

• Almost half of the time spent in the authorization process is utilized making these calls.
HOW TO USE THE 278

• Real-time unfavorable 278 responses received during the pre-registration process can be formatted and immediately forwarded electronically to referring providers as reminders.

• Pre-scheduled 278 requests can be re-submitted to payers to re-check authorization status.

• Unfavorable 278 responses can be pre-sorted by patient type into reports that could be automatically routed to Case Management, Patient Access or Patient Accounting for follow-up.
BENEFITS

• 20% FTE savings
• FTEs shifted to coordinate data exchanges between Patient Accounting and Utilization Management
IMPLEMENTING THE 276/277
CURRENT STATE

• Electronic options limited today
• Hidden armies of telephone-wielding staff
  – Typical 300- to 400- bed hospital has 10 to 13 FTEs dedicated to following up on accounts
  – Each call takes up to 10 minutes
BENEFITS

• Claim Status Inquiry makes up 40% to 50% of current FTEs.
• 25% to 30% impact to staffing.
• FTEs shifted to resolve OP small balances and improve efficiency with HMOs, dramatically improving cash flow and reducing write-offs.
GRADUATE LEVEL STRATEGY

• Use automated 276 queries to accelerate the revenue cycle.
• Imagine a 276 sent one week after electronic billing:
  – Not eligible – immediate self-pay or claim correction
  – Medical records request – respond immediately – 2 week follow-up 276
  – Claim missing – resubmit
  – No status yet – 276 again in 1 week
OVERALL
OVERALL OPERATIONS IMPACT

• Revenue cycle dramatically affected
  – Providing opportunities to achieve efficiencies
  – Automation will substantially alter roles in Patient Accounting
  – Should not reduce staff
  – Seizing opportunity to realign staff, improving revenue cycle operations
## FINANCIAL IMPACT

### 350-Bed Hospital

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>$187,500</td>
</tr>
<tr>
<td>Bad Debt Reductions</td>
<td>$1,875,000</td>
</tr>
<tr>
<td>Authorization Denial Reductions</td>
<td>$750,000</td>
</tr>
<tr>
<td>Other Cost Savings</td>
<td>$20,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$2,832,500</strong></td>
</tr>
</tbody>
</table>

ONE PAGE SUMMARY

• Workflow
• Workflow
• Workflow
• Workflow
IMPLEMENTATION CONSIDERATIONS

• Well structured and timely implementation process
  – Systems, Operations, Organization
  – Vendors Plan
  – Payers Plan
  – Testing and certifying transactions
  – Current electronic processes
    • Billing, verification, cash posting
    • Authorizations, pre-registrations
IMPLEMENTATION CONSIDERATIONS

• Well structured and timely Implementation Process (cont’d)
  – Work Groups
    • Registration areas
    • Patient accounting
    • Utilization management
    • Medical records
    • Information services
PARTING THOUGHTS

• In the revenue cycle, technology is important.
• Its value increases with the quality of the process it supports.
• Electronic transactions are not just faster versions of paper and voice transactions – they are a quantum leap.
• Taking proper advantage of quantum leaps requires new thinking about the old problems.
Questions?

If you have questions later, please feel free to email us:

jthompson@phoenixhealth.com
tgrove@phoenixhealth.com